IN THE CIRCUIT COURT OF THE
SIXTH JUDICIAL CIRCUIT IN AND FOR
PINELLAS COUNTY, FLORIDA
CASE NO.: 97-5968-CI-11

JOHN EASTMAN,

Plaintiff,

vs.

VOLUME XXV

BROWN & WILLIAMSON TOBACCO CORP., individually and as successor by merger to THE AMERICAN TOBACCO COMPANY, a foreign corporation; PHILIP MORRIS, INCORPORATED, a foreign corporation,

Defendants.

BEFORE: HONORABLE ANTHONY RONDOLINO
PLACE: The Judicial Building
545 First Avenue North
St. Petersburg, Florida
DATE: Tuesday, March 25, 2003
TIME: 1:10 p.m. - 4:50 p.m.
REPORTED BY: TONYA H. MAGEE, RPR
Court Reporter and Notary Public
Sixth Judicial Circuit

TRIAL PROCEEDINGS

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THE COURT: What's next?

MR. ACOSTA: Judge, the defense is going to read their cross-examination of Dr. Back, and then we're going to try to show some video, but the sound is not very good. And on one of them, we're going to show it for a couple of minutes, then I was just going to freeze the picture and then read the rest of it. And then on the other one, it -- it goes in and out, and so there might be a few thing that they're difficult to hear and we'll try to read some of it, if we have to. But otherwise, we're going to play it through. And I just have to let you know that the sound is terrible on it, unlike the last one.

THE COURT: You should do it through the manuscript.

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MR. ACOSTA: Well, my theory was that John Moss' blackberry was on and it was -- you know, it was interfering with the -- the camera, but --

MS. FAGGIANELLI: That's a new one.

MR. ACOSTA: -- I don't know for sure, because it worked in the other video.

MR. LYDON: We weren't quite sure what the

blackberry chips were.

MS. FAGGIANELLI: Now we know.

MR. ACOSTA: I just don't know. I don't know.

THE BAILIFF: You ready for the jury?

THE COURT: I am.

MS. FAGGIANELLI: Your Honor, would you explain to the jury that we're just doing the cross-examination of Dr. Back?

MR. CHRISTOPHER: They know through the video before and now it's with me.

THE COURT: All right.

(The jury entered the courtroom, after which the following proceedings transpired:)

THE BAILIFF: The jury is present and seated, Your Honor.

THE COURT: Okay. Thank you, Sheriff.

Ladies and gentlemen, if you remember from before lunch, you saw the video deposition testimony of the physician. After lunch, now we're going to be engaging in cross-examination, but to speed things along, the editing process probably works better this way. Instead of showing the video of the answers to the questions given by the witness, they are going to read those in the format that we have done before. So at this time I guess

Mr. Christopher is going to play the part of the witness and the questions are asked directly from the transcript of the deposition.

MR. CHRISTOPHER: Thank you, Your Honor.

(Whereupon, excerpts of the cross-examination of the deposition testimony of Martin R. Back, M.D. was read to the jury, with Ms. Faggianelli reading the questions and Mr. Christopher reading the answers, as follows:)

Q. Do you have some records available to you sitting before you that would identify the exact location of the abdominal aortic aneurysm, vis-a-vis where it starts in the aorta and where it ends?

A. Yeah. In the first notes dated November 4th, 2002, there's mention made of a juxtarenal abdominal aorta aneurysm, and that was to my interpretation of the CT scan or the CT scan that was done to diagnose the aneurism. What juxtarenal means is that the aneurysm begins in the region right around the kidney arteries that branch high in the abdominal region and make the repair of the aneurysm somewhat more complex. His aneurysm extended down into the end of the aorta, into its branching site at the iliac arteries, and he had evidence of atherosclerotic disease in the iliac arteries on both sides.

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Q. Do you have a copy of the CT scan report upon which you are relying when you made your assessment of the location?

A. Not a copy of the CT report. The actual films. And those are in my office at the Veterans hospital, where I'm the chief of vascular up there.

Q. I'm going to show you one of the records from the VA Hospital. It's the CT scan report dated October 30th, 2002, and it's Bates number 200363.249.0087, and ask you whether this CT scan report is consistent with what you just told us regarding the location and extent of the abdominal aortic aneurysm.

A. Most importantly, the CT scan was obtained fairly recently, October 30th, 2002, which is pertinent to aneurysms which can change in size. So it's a fairly recent CT scan. The description here is that the aneurysm reaches a maximal dimension of 6.4 centimeters in a segment of the aorta below the kidney arteries and down toward the bifurcation or the branching site of the aorta. The maximal dimension of the aorta at the level of the superior mesenteric artery, by the description here, is 4.3 centimeters, and that's consistent with my finding. That's what makes it a juxtarenal aneurysm. That is, the aorta doesn't come back to a normal diameter at the level of the renal arteries. It is

enlarged or widened.

(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)

MS. FAGGIANELLI: Can we have the slide?

(Whereupon, the reading of the deposition continued, as follows:)

Q. Because these curves in the anatomy are somewhat obscured to laypersons, I brought with me a picture that purports to show the aorta, and I'm going to show this to you. And I've got a copy for counsel. Let's put it on.

I want to ask you whether or not, number one, do you think this is a reasonably accurate representation of the aorta and other anatomical structures nearby?

A. Yes, it is.

Q. Okay. Let me ask you another question. Since you said that it's a reasonable representation, I didn't want to cut you off, so go ahead and explain what it is if you think you can add something further.

A. These drawings are made from cadaver dissections and this shows relatively normal anatomy related to the aorta; that is, a nonaneurysmal aorta.

Q. On this diagram, if I give you something to mark with, can you identify -- oh, you already have

something. Excellent.

Can you identify the level at which the aneurysmal changes begin and the levels at which they end? You can feel free to go ahead and write on there. We'll March this as an exhibit.

A. His aneurysm begins at the level of and just above the renal arteries. So I've drawn an arrow here pertaining to the locations of the origins of the two

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kidney arteries that come off to the right and to the left and at the region where the superior mesenteric artery is, which is the main artery going into the intestines -- one of the main arteries going into the intestines. His aneurysm extends down to the end area of the aorta, which is called the bifurcation region. His iliac arteries, which are beyond this branching point of the aorta, these two iliac branches going to both of the legs and also have some branches into the deep pelvic area, showed heavy calcification consistent with atherosclerosis, as described in the report and to my -- and it's consistent with my interpretation.

Q. So the arrow you put on top here indicates where the aneurysm started?

A. Where it begins.

Q. Where it begins. The arrow at what is call the bifurcation where the aorta splits in two is where

the aneurysmal changes ended but -- and below that you saw some additional atherosclerotic changes bilaterally --

A. Correct.

Q. -- is that fair to say?

A. Correct.

Q. Would you just initial that and date it. And I will ask the court reporter to have that marked as deposition Exhibit Number 1.

(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)

MS. FAGGIANELLI: You can take the slide down. Thank you.

(Whereupon, the reading of the deposition continued, as follows:)

Q. I would like to ask you a few questions now about Mr. Eastman's history and risk factors for abdominal aortic aneurysms. Are you familiar with risk factors in general for abdominal aortic aneurysms?

A. Yes.

Q. Were you familiar with Mr. Eastman's history of radiation therapy for treatment of testicular of seminoma in the late 1960s?

A. No, I was not.

Q. Are you familiar as you sit here today with

radiation therapy protocol for treatment of testicular seminoma circa. 1960 to '65?

A. Not in that era, no.

Q. What are the sources that you would want to look at to determine the radiation protocol given to patients for testicular seminoma in the early 1960s?

A. A textbook that a -- or a textbook that was available at that time on oncologic procedures and management with radiation therapy.

Q. I'm going to tender to you this document and ask that you identify it, if you can.

A. Textbook of Radiotherapy, authored by Gilbert Fletcher, M.D.

Q. And on the next page?

A. Copy from M.D. Anderson Hospital.

Q. On the next page, I think it identifies the year that this book was initially published?

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A. 1967.
Q. I actually see a copyright date of 1966; is that correct?
A. 1966 at the bottom, correct.
Q. Can you turn to page 527 of that textbook chapter. I'm going to ask you a couple of questions about that. But is this the kind of radiotherapy textbook from the '60s that you would find to be a

reliable resource for determining what the treatment fields were for testicular seminoma in the 1960s?
A. Yes.
Q. So do you believe that a textbook published in 1966 with respect to radiotherapy would be a reasonable indication of what the treatment protocol would have been for testicular seminoma in 1961 and 1962?
A. Appropriate, yes.
Q. And can you, in terms that we can understand as nonphysicians, describe what this diagram in the lower left-hand corner of page 527 is?
A. The radiation fields would include the middle portion of the abdomen or stomach area, extending up into the very lowest portion of the chest and extending down to adjacent to the groin regions or the pelvic regions.
Q. And would patients, based upon these radiation fields identified in the diagram, receive radiation given both to the front of their body and to the back of the body?
A. Correct.
Q. In this diagram, does it identify whether or not treatment fields set up there are for left versus right side in testicular seminoma?
A. In figure 11, dash, 12, this is pertinent to a

seminoma of the left testes so that the radiation portal deviates toward the left pelvic region.
Q. Does the radiation field in the abdominal midline also deviate slightly so that the center of the field travels just to the left of the spine?
A. Correct.
Q. Is that also where the aorta travels in the abdomen cavity, just to the left of the spine?
A. Just to the left of the spine, correct.
Q. Having had the opportunity to review the Textbook of Radiotherapy chapter on the treatment of testicular seminoma published in 1966, is that a reliable resource that you would consider reasonable for determining the treatment protocol for testicular seminoma?
A. Yes, at that time.
Q. I would like to turn our attention to the abdominal aorta more particularly. I think at the last deposition you gave a nice description of what is an aneurysm, and I would just like to ask you a few follow-up questions that relate to the anatomy of the aorta. And in particular, can you tell how -- what how -- what makes up the wall of the aorta, the wall of that vessel?
A. Three different layers, an inner layer that is

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the inner lining that's in contact with blood flow, the intima, does not have much strengths related to it, but regulates clotting mechanisms at its surface.

The second layer is the media, which is primarily a muscle layer that provides some strength, but also gives the ability for the vessel to change its width or diameter by contracting or relaxing the muscles?

And finally, the outer layer, called the adventitia, which is primarily the strength layer in the aorta and is composed primarily of fibrous tissue which is -- which provides the strength. It does not have much activity in terms of clotting mechanisms and it does not necessarily contract and change the width of the vessel.

Q. So there are three layers to the wall of the vessel?

A. Correct.

Q. What is the vaso vasorum?

A. Those are very small, microscopic blood vessels within the wall of these larger blood vessels that provide nutrients to the wall of the vessel.

Q. Where is this group of vessels that provide nutrients in the abdominal aorta?

A. It's primarily in the outer layers in most

vessels. The infrarenal aorta that is below the renal arteries has a relative posity of vaso vasorum.

(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)

MS. FAGGIANELLI: And could I have the slide, please?

(Whereupon, the reading of the deposition continued, as follows:)

Q. Turning your attention to the deposition exhibit that you marked at the time of your first deposition, I've gotten some different colors today, first of all, in case you want to use them. Can you identify in this exhibit the structures that were the target of the radiation treatment for seminoma?

A. Roughly those boxes from that figure that you showed me earlier that would involve this area and potentially down here into the groin or deep pelvic region.

Q. And you've marked those areas in red on this diagram?

A. Correct.

Q. Within those fields was there a particular part of the anatomy that the seminoma was suspected to be in that they were trying to treat?

A. Within the lymph notes that are adjacent to

the aorta and the pelvic arteries.

Q. Can you use a green marker and just draw an arrow to the peri-aortic lymph nods?

A. Some of these lymph notes here we can draw arrows or we can circle the lymph nodes that are shown on the diagram themselves.

Q. Okay. You've identified -- and those would be on both sides of the aorta, correct?

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A. They are on both sides of the aorta. More so here between the aorta and the vena cava.
Q. Can you just label that, I guess, just pull that arrow out and just label the --
A. Let's call it LN for lymph node.
Q. Maybe with the red do a similar label just for later on that identifies the irradiation.
A. Let's call that XRT for irradiation.
Q. Okay. The per -- I'm sorry, where do the peri-aortic lymph nodes lie with respect to these vessels that are called vaso vasorum?
A. They are outside of them. Outside of the aorta, but adjacent to them.
Q. What does adjacent mean?
A. Within several centimeters of distance.
Q. All right. Having had the opportunity to review the CT scan today, can you tell me, based upon

what you previously marked in deposition Exhibit Number 1, with this arrow as being the area where the aneurysm began, whether that remains accurate or whether that needs to be revised at all?
A. No, it's accurate. It's at the level of the -- adjacent to the superior mesenteric artery and the celiac artery.
Q. Can you just label that arrow as something to indicate that that's where the aneurysm begins?
A. AAA is a marking for aneurysm.
Q. And then can you identify or just confirm again, I guess, that you had put an arrow here at the bifurcation to indicate where the aneurysm, approximately where it ended; is that correct?
A. Yeah. We'll call the top one B, for beginning, and the bottom AAA, slash, E, for ending.
Q. Okay. I would like to ask you a couple of questions now about how the effects of irradiation --
(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)
MS. FAGGIANELLI: I'm sorry.
(Whereupon, the reading of the deposition continued, as follows:)
Q. -- (continuing) about the effects of irradiation on vessels. Do you have any background and

training with respect to the effects of irradiation on vessels?
A. I have knowledge of it. I have not done any specific research myself.
Q. What is the source of your knowledge?
A. Textbooks, published papers and peer-reviewed journals.
Q. And is that a source of knowledge that's commonly relied upon by physicians who practice in your field?
A. Correct.
Q. Can irradiation of vessels cause trauma that results in calcified changes?
A. It depend if you're specifying on the size of the vessel being treated or the size of the effect of the vessel that is being irradiated.
Q. What are the calcifications when you are

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talking about what you see in vessels on CT scan?
A. Calcification is deposition of calcium similar to the calcium deposits that occurs in bone that can occur within a diseased artery. It's part of the atherosclerotic process. It affects large arteries only. That is arteries any smaller than a millimeter or so don't tend to be affected by atherosclerosis and calcification.

Q. What's the size of the vaso vasorum, those vessels in that network in the scale of all of the vessels?
A. The smallest, microns. Microns are millions of a meter. These are the smallest vessels.
Q. And based upon your knowledge of the effect of irradiation on vessels, can irradiation damage small vessels?
A. Yes, it can.
Q. What kinds of damage does irradiation cause to small vessels?
A. It causes an inflammatory process to occur within those vessels that lead to -- many times to thrombosis and obliteration of those small vessels, sometimes referred to as radiation-induced arteritis, which just implies that there's inflammation in those small vessels.
Q. Are there certain recognized consequences of the obliteration of small vessel?
A. Yes, there is.
Q. What happens when small vessels are obliterated?
A. An example of radiation to the pelvic region, which also involves the blood vessels supplying the intestines, is that you can get an obliteration of the

blood vessels to those intestines resulting in structures or scarring processes within those small vessels that supply the wall of the intestines. So that's evidence of damage to the organ supplied by the small vessels.
Q. Are the vaso vasorum within this group of small vessels that could be damaged by irradiation?
A. Yes, they could potentially be.
Q. And would the tissues that receive nutrients and oxygen from the vaso vasorum, are those within the tissues that could suffer damage from the obliteration of the vaso vasorum?
A. Correct.
Q. How many patients have you treated who had irradiation of the fields you've indicated in this exhibit in the early 1960s?
A. Not many.
Q. Can you recall any others?
A. Not specifically, but we've had many patients with concomitant malignancies, or malignancies, cancers in the past involving the intraabdominal region, some treated with radiation and not specifically with aneurysms, but with associated atherosclerotic occlusive disease.
Q. Were those patients that you're recalling

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treated with radiation in the early '60s?
A. I couldn't say specifically.
Q. In the patients that you have treated in your experience with a history of irradiation to vessels that have atherosclerotic changes, do you see a particular pattern of distribution of those changes in the irradiated part of the vessel versus the nonirradiated part of the vessel?
A. The atherosclerotic process can be accelerated; however, those patients may have other risk factors for atherosclerosis as well.
Q. Is infertility one of the side effects that you know about based upon your knowledge of radiation therapy side effects and its effect on the body from your medical training?
A. It is potentially, as is chemotherapy.
Q. I would like to move on and talk a little bit about heredity as a risk factor for abdominal aortic aneurysm. Is that something that you studied during the course of your training?
A. Correct.
Q. Has that a developing field of particular interest in the field of vascular surgery in the last decade?
A. It has.

Q. Why is that?
A. It was initially observed that approximately one in five aneurysms seem to occur within families; that is, that there were other relatives, blood relatives within the family that had developed aneurysms. So there's an ongoing surgery for the -- what exactly are those genes specific for passing on hereditarily the predisposition to aneurysms. That has not been identified as of yet. And it may be multiple genes, not a single gene.
Q. Has that body of research resulted in any screening programs for people who have relatives with aneurysms?
A. It has.
Q. What are the nature of those screening programs?
A. General recommendation followed by our university practices and recommended to other primary care physicians is an ultrasound being performed of the abdominal aorta, again, the most common site for an aneurysm to form, in first-degree relatives over age of 50, with potentially repeating the ultrasound study several -- five years later or so in patients not found to have an aneurysm initially.
Q. Has the research into heredity also been tied

to certain research regarding pathological changes in the wall of the aorta associated with those people that develop aneurysms versus people that don't?
A. There are certainly accepted and acknowledged changes in the arterial wall that is degeneration of the media and the adventitia, weakening of the all, structural weakening, as well as evidence of the weakening process based upon different proteins or

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chemicals that can be sampled within the blood in patients who have aneurysms versus patients who don't have aneurysms.

Q. Is age a risk factor for the development of an aneurysm?

A. Yes.

Q. And what age has been associated with the increased risk of aneurysm?

A. The peak incidence of aneurysms, that is age at which patients are most likely to develop an aneurysm, is in the range of 70 to 75 years of age. Aneurysms can occur earlier, but typically not before 50 years of age. And they can occur in 80 years old or older, but less commonly so.

Q. Is gender considered to be a risk factor for development of aneurysms?

A. For abdominal aortic aneurysms, males

outnumber females five to one.

Q. Are there a long list of theoretical contributors to abdominal aortic aneurysms that are still being studied?

A. Yes, there are.

Q. And what are those?

A. Again, the variant of atherosclerosis is the degenerative process that occurs in the outer wall may have some other stimulators that are not known. There are hemodynamics or flow-related phenomenon from the inside of the abdominal aorta that may predispose it to dilation because of decelerative or slowing down of blood flow that can occur in the abdominal aorta, although there's -- those are theories and are not necessarily supported by causal relationships.

Q. Is it fair to say that the mechanism, the specific mechanism by which atherosclerosis is considered to ultimately lead to the development of an aneurysm is still theoretical and subject to further scientific review?

A. That's a fair assessment, yes.

Q. Are you familiar with the work of Dr. Tilson on heredity?

A. I am.

Q. Who is Dr. Tilson?

A. He's a professor of vascular surgery, professor of surgery. He's at a New York hospital, I believe, New York Columbia. He's published extensively on aneurysms and associations with hereditary factors.

Q. Has there been any consensus developed with respect to the role of heredity among vascular surgeons based upon the work of Dr.Tilson and others that have followed that research?

A. That is that there may be some specific genes related to the development of aneurysms, yes.

Q. In the patients that you've treated who are nonsmokers but who have aneurysms, do you have a theory in that group of people as to what caused their aneurysms?

A. I don't have a theory. Again, there may be familial relationship. The other acknowledged risk factors potentially for aneurysms are high blood

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pressure in approximately 75 percent of these patients, again, overlapping the atherosclerotic population.

Q. I've just got a couple more questions, and they relate to Mr. Eastman's CT scan over there.

I guess I would like to direct your attention to three segments of the aorta in Mr. Eastman, the first segment being above the diaphragm, and ask you just generally if you can characterize the nature and extent

of any changes that are -- or calcifications that you can see there?

A. He has some calcifications of the descending thoracic aorta that's in the lowermost portion of the chest cavity. That's where the CT's scarred, so we don't get the benefit of the entire aorta all the way up into the chest. But there is some calcification in that level. Because intravenous contrast was not used in this study, we also don't get any really details about the intimal disease process or clot distribution within the aorta itself, which would give you an indication as to the amount of disease in the wall.

And the last thing you can see from the plane film here is that his aorta we would describe as relatively tortious. The atherosclerotic -- or the aneurysmal process is one associated with both dilation of the vessels and elongation, so it's got some -- it's got some tortuosity to it.

Q. With respect to the calcified changes above the diaphragm, do they go -- are they completely circumferential?

A. They are noncircumferential or scattered.

Q. Kind of sporadic Dick?

A. Sporadic.

Q. Can you compare or contrast in general the

nature of the calcific changes below the diaphragm versus those above?

A. Below the diaphragm there's much more extensive calcification in the wall of the aorta than there is above.

Q. Based upon your experience in the patients in the population that you've treated, can you put the changes you see in Mr. Eastman's aorta with respect to the extent of those calcifications that you see on a spectrum among all the patients that you've seen during the course of your career?

A. Probably one in ten aneurysms have extensive calcifications associated with it. He's in the upper tenth percentile.

Q. The high end?

A. The high end in terms of amount of calcium.

Q. Is there anything, any positive finding that you've seen in Mr. Eastman's medical records outside of the field of this CT scan that identifies significant diffuse peripheral vascular disease or atherosclerotic changes?

A. It doesn't appear to be documented. I'm not aware of it.

Q. So as you sit here today, the only location that you can state with reasonable medical probability

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that Mr. Eastman has significant atherosclerotic changes based upon the medical evidence is in the distribution that is identified on Exhibit Number 1 to the initial deposition; is that correct?

A. Correct.

Q. Do you recall what Mr. Eastman's reason was for wanting to defer surgery?

A. To continue the court proceedings relating to this case.

Q. Do you recall any specifics with respect to that conversation?

A. Specifics being that it was important for him to continue these court proceedings, that he -- that could not be delayed, according to him. If he was to have his aneurysm repair, that he wanted to complete the court interactions and then proceed with the repair of his aneurysm.

Q. Can you characterize for me the level of urgency that you communicated to him with respect to the need to definitely treat his aneurysm and whether further delay would change the risks of that procedure?

A. The large size of his aneurysm is a risk, has a fairly high risk of rupture associated with it. The severity of his obstructive disease in his lungs also would predict a higher risk of rupture related to -- in

addition to the size of the aneurysm.

I stated to him that I thought he was at a very high risk of rupture within the coming months, in fact, especially if he had delayed that. And I -- this statement here is that what was transcribed was a 25 percent risk of rupture within the ensuing months, you know, and that his chances of getting through this operation were optimal only under elective conditions.

It this was an emergency situation, and he ruptured his aneurysm, I think that his chance of survival of any emergency procedure would be so low that it would not be worth undertaking.

So that -- so that it would be somewhat risky to wait getting the aneurysm fixed when we thought he was in as optimal condition as could be from his lung standpoint and that any rupture of the aneurysm during that ensuing period of time would probably not be addressed with surgical intervention. He would be allowed to die.

Q. Did you approve of his decision to delay surgery?

A. I agreed with it, but informed him of the risks associated with it.

(Whereupon, the reading of the deposition concluded, and the following proceedings

transpired:)

MS. FAGGIANELLI: That's all, Your Honor.

THE COURT: All right. That completes the testimony of the doctor. What's next?

MR. ACOSTA: Your Honor, at this time the Plaintiffs would like to try to play the deposition of Dr. Tinsley. It has very bad sound in it, and so eventually we'll have to stop it and read from

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thereon.
THE COURT: Okay.
MR. ACOSTA: This is -- this is the deposition Dr. Steven B. Tinsley, M.D., taken February 5th, 2003.
(Whereupon, an excerpt of the videotaped deposition testimony of Steven B. Tinsley, M.D., was played to the jury, as follows:)
BY MR. MOSS:
Q. Could you state your name for the record?
A. Steven B. Tinsley.
(Whereupon, there was an interruption in the playing of the videotaped testimony.)
Q. Could you state your name for the record?
A. Steven B. Tinsley.
(Whereupon, there was an interruption in the playing of the videotaped testimony.)

Q. Could you state your name for the record?
A. Steven B. Tinsley.
Q. Can you identify the records that you've brought with you? What do they include?
A. They include my initial evaluation of Mr. Eastman when I saw him in the emergency room on June 10th, 1995. They include a discharge summary of when he was discharged from the hospital. There's an ER physician's report here from when he was admitted to the hospital. There's two offices visits here from when I saw him in follow-up from the hospital.
There's an EKG. And then there's some administrative materials including the bill that's here, the billing from them, including information as far as regarding addressing -- addresses and billing information, how to contact the patient. There's a few -- there a few copies of prescriptions here, also.
Q. All right. And prior to the deposition today, did you have an opportunity to review your office chart?
A. Yes.
Q. What is your specialty?
A. I do -- I have a specialty in internal medicine, and I also have a subspecialty in pulmonary and critical care medicine.
Q. What do you do in your capacity as an internal

medicine physician?
A. I care for people's medical -- general medical conditions, which can include pulmonary disease but include heart disease, diabetes, high blood pressure, preventive testing.
Q. Do you treat only adults, or do you treat children as well?
A. Only adults.
Q. Can you describe for me the percentage of patients you see that come to you in your capacity as a primary care physician or an internist as opposed to those who are seeking your care in your capacity as a pulmonologist?
A. Probably approximately 55 percent as internal medicine and about 45 percent as pulmonary.
Q. Are you board certified in any field?
A. I'm board certified in internal medicine. My

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board certification in pulmonary medicine has expired a couple years ago. But I was boarded at one point.

Q. Is pulmonology one of the fields these days that requires periodic recertification?

A. Yes, it is.

Q. How frequently does that specialty require recertification?

A. Every ten years.

Q. When were you last board certified in pulmonary medicine?

A. 1990.

Q. When were you certified -- board certified in internal medicine?

A. I believe I was board certified in internal medicine, I believe it was 19- -- I believe it was 1988.

Q. Where did you attend medical school?

A. I went to medical college of Virginia, Richmond, Virginia.

Q. And what years did you attend medical college in Virginia?

A. 1981 to 1985.

Q. Based upon your review of the records today, can you tell me the date that you first saw Mr. Eastman --

(Whereupon, there was an interruption in the playing of the videotaped deposition testimony, and a conference was held outside of the hearing of the jury and the court reporter, after which the following proceedings transpired:)

THE COURT: Folks, we're going to go into reading the deposition at this time because the audio gets even worse. Mr. Denson is doing the answers and Mr. Acosta is doing the questions. Mr.

Denson will have a chance to see what it looks like from the witness stand.

(Whereupon, excerpts of the deposition testimony of Steven B. Tinsley, M.D. was read to the jury, with Mr. Acosta reading the questions and Mr. Denson reading the answers, as follows:)

Q. As a general medical student before the time period that you decided to specialize in pulmonary care later on, what did you learn about the relationship between smoking and health?

A. Smoking, generally speaking, had an adverse impact on health.

Q. What did you do in the years following the your graduation from medical school to pursue further training?

A. I did an internship and residency in internal medicine at Shands Hospital, University of Florida, and then I did my pulmonary fellowship at Shands Hospital, University of Florida.

Q. What year did you complete your pulmonary fellowship?

A. 1990.

Q. So having completed your fellowship, you've been in the Tampa, St. Pete and Clearwater area, you were there between 1990 and 1995, correct?

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A. Right, correct.
Q. During that time period did you become familiar with the practices of your peers in talking with patients about smoking and health?
A. Yes.
Q. And was it your understanding that physicians similar to yourself routinely spoke to patients about smoking and health?
A. The majority of the physicians, yes, would discuss with the patients the relationship between smoking and health.
Q. Would you offer any further advice to the patients who came to you with a smoking history in those years between 1990 and 1995 in addition to telling them about the relationships between smoking and health?
A. I would -- I would have a general discussion about the relationships between smoking and health and would oftentimes advise them to reduce and discontinue tobacco use if at all possible, and oftentimes would discuss various strategies available to assist them if that was their desire.
Q. If the patient communicated to you a desire to quit smoking, what strategies and assistance would you offer to them?
A. Well, I would discuss the support groups that

are available. Various communities do have support groups associated with hospitals, similar to like the support groups you would say in Weight Watchers. There are support groups available.
There are -- biofeedback can be taught. I don't personally teach them, but I can always make a referral to someone who would deal with that. More recently we've had a various degree of tobacco -- nicotine-related products.
Q. I just want to make sure the record is clear. I'm asking for -- I want you to be particular to the time period I'm talking about, between 1990 and 1995.
So if you need to rephrase your answer in any way up to this point, then please let me know. But in this time periods between 1990 an 1995.
A. I'm not certain when -- actually, yes, I'm certain there were nicotine products available as far as Nicorette gum was available, and I believe it was around that time that the patches start becoming widely available as an assist to break the habit of tobacco use. I would also offer anxiolytics to patients to assist them in their discontinuation of tobacco use.
Q. Based upon your review of the records today, can you tell me the date that you first saw Mr. Eastman, the plaintiff in this case?

A. The first time I saw him on was on June 10th, '95.
Q. Based upon your review of the office chart you have there, is it your understanding that Mr. Eastman presented to the emergency room on June 10th, 1995 and that you were called in as a consultant to participate in his care?
A. He did present on June 10th, '95 to the

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emergency room, and I was called to the -- be the admitting physician for him.

MR. MOSS: Why don't we go ahead and have the hospital record marked as an exhibit so that Dr. Tinsley can review it and we can be talking about the same thing. Because these have Bates numbers on them, it will be easier for the record.

Q. Sir, I'm tendering to you what is going to be marked as Exhibit Number 2 to your deposition. Can you identify that for the record?

A. It looks like the inpatient record of Mr. Eastman during his hospitalization from June 10th, '95 to June 20th, '95.

Q. Does it appear to be a complete copy of the hospital record from that admission from the Morton Plant Hospital?

A. It appears to be, yes.

Q. Can you identify in there the emergency room sheet that would reflect Mr. Eastman's condition upon presentation to the hospital?

A. There is a dictated assessment from the emergency room physician and there's an actual ER sheet which is the form generated there in the emergency room, yes.

Q. Okay. Let's -- if we can, let's turn to that page 17, the emergency room physician's dictated report.

Based upon -- and just, as I said before, if you feel more comfortable reviewing the handwritten sheet that you know that you would have reviewed when you came to the hospital in conjunction with that, just so you know you're talking about something that would have been available to you when you first saw the patient, please do so.

So based upon the records that were available to you when you undertook Mr. Eastman's care, what did you know about his history?

A. Well, again, you do review the records, but you also go discuss it in detail with the patient itself. Are you talking about my complete ER evaluation or just the records that were available to me?

Q. Well, I don't want us to get bogged down in which records were available to you and which weren't.

I just want to know what you assessed, what you considered when you first saw the patient.

And if the easiest thing to do is to look at your dictated consultant report, then we can just go there.

A. No, the concern was that he may have had pneumonia. There was concerns there may be what we call an early lower lobe -- right lower lobe infiltrate. And we knew that he was hypoxic, he had low oxygen levels and was requiring supplemental oxygen.

The other concerns were the infectious process. Given his history of tobacco use, he may have had underlying obstructive pulmonary disease that the infectious process may be exacerbating and continuing -- and contributing to his overlying -- his underlying medical status that required his hospitalizations.

Q. What contributed to your diagnosis of

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pneumonia?
A. He had a low-grade temperature, a temperature of 100.3, which is low grade. He had a slightly elevated white count. He had low oxygen levels. The suggestion of an infiltrate in his right lower lobe. He had a productive cough of purulent phlegm and he had physical exam findings that were suggestive of pneumonia, which would be what we call rales in the

right base. And the combination of the clinical picture led to a strong suspicion of pneumonia.
Q. In lay terms, what is the pneumonia?
A. Pneumonia is an infection of the lower respiratory tract, of the actual infection within the oxygen exchange units in the lung.
Q. Based upon what you see here with respect to the lab values you've already described, did you have a believe then or now as to whether or not the pneumonia that was diagnosed was more likely viral or bacterial?
A. The suspicion was bacterial.
Q. Is there any difference in terms of the clinical significance from a pulmonary standpoint to a viral versus a bacterial pneumonia?
A. The biggest difference is that a bacterial pneumonia will respond to antibiotic therapy and viral pneumonia will not. It will have to run its course.
Q. In terms of what's actually going on in the oxygen exchange part of the lung, is there something that's different in a viral pneumonia versus a bacterial pneumonia?
A. The biggest difference is often viral pneumonias -- these are just tendencies, not a hundred percent blanket in all patients -- but the tendencies are vial pneumonias can typically be more diffuse, can

affect larger segments of the lung, whereas bacterial pneumonias are often more focal, involving more segments of the lung rather than diffuse patterns.
Q. How do you differentiate a viral pneumonia from a bacterial pneumonia in a clinical setting such as this?
A. Generally speaking, viral pneumonias tend -- the coughs tend not to produce phlegm, they tend to be a dry, nonproductive cough. That's one of the biggest differences.
In the differential of the white counts, you can at times see more of a lymphocytosis. Lymphocytes will be higher. Whereas in the bacterial, you'll see an elevation of the segs or the polys, which tend to indicate more bacterial.
Q. What did you see in the labs in this case?
A. Predominantly an elevation of the segs and that his lymphocytes were actually depressed. So the clinical presentation and the laboratory values were more suggestive of a bacterial pneumonia than a viral pneumonia.
Q. Is it possible that nonetheless that it was a viral pneumonia? Can they be ambiguous sometimes?
A. Yes, they can.
Q. Was it possible to absolutely rule out a viral

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pneumonia in this case?
A. In this case, no. The only definitive way to make a diagnosis of a viral pneumonia, even though we can have overwhelming evidence, and we seldom ever do that is actually do with a lung biopsy to see the viral inclusion within the cells itself. And we almost never do that.
Q. So even a viral pneumonia can also present with a patient with a productive cough?
A. Depends on -- depend on what the patients underlying disease status is. The viruses sometimes can lead to irritation in the airways, which can lead to mucous production, so yes.
Q. In Mr. Eastman's presentation on June 10th, 1995, his temperature was 100.3, correct?
A. Correct.
Q. Would you sometimes expect a bacterial pneumonia to present with a higher temperature?
A. Bacterial and viral pneumonias can present from anything to low-grade temperature to -- anything from low-grade temperatures, hypothermia, all the way up to very high spiking temperatures. Depends on what stage you catch it at and the virulence of the organism that is actually involved.
Q. Was Mr. Eastman's white count of 11,400 only

slightly elevated?
A. Slightly elevated.
Q. Would that suggest more likely a bacterial or a viral infection, or is it ambiguous?
A. It's ambiguous.
Q. In the case such as Mr. Eastman's, are you prescribing antibiotics kind of in the dark, you're hoping that if the patient gets better with the antibiotics quickly that would suggest to you that it was bacterial?
A. There are times in which a response to antibiotics can be highly suggestive of bacterial process. That does not always indicate -- the rate of the response does not necessary indicate bacterial versus viral.
With severe pneumonias or with people with underlying lung disease, their symptoms can be more protracted. And also it depends on if you've made the right choice of antibiotics.
You never have culture results or anything back like that at the time you choose antibiotics. You choose antibiotics based upon what you think the most likely causative organism would be, and sometimes you're wrong.
Q. How long had Mr. Eastman been suffering

symptoms before he presented to the hospital on June 10th, 1995?
A. Two weeks.
Q. During that two-week period of time, what would be going on in his lungs?
A. It depends on the exact cause. Again, you want me to restrict just to pneumonia?
Q. Based upon Mr. Eastman's -- yeah, with respect

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to pneumonia.
A. Okay. First off, many bacterial pneumonia can be what we call post viral, so that sometimes people start off -- start off with a viral upper respiratory tract infection that weakens your -- weakens your defenses such that you can become -- such that you can then become superimposed with a bacterial pneumonia?
The durations of the symptoms is generally again -- if pneumonia is the only causative problem, is generally against a viral syndrome because viral syndromes are usually self-limited and would have resolved before a two-week period.
Some of the exceptions you may see is specifically in Mr. Eastman's case when he does have some underlying lung disease where a viral syndrome can start an inflammatory process as in chronic obstructive pulmonary disease, and despite the clearing of the

virus, you still have the results of the inflammation and have to treat the underlying disease process, which would be the chronic obstructive pulmonary disease, before a patient would have resolution of the symptoms?
So the time period would make you be somewhat less suspicious of viral process at the time that he was admitted, but not to say the viral process may not have started it.
When a person with underlying lung disease first gets the infections, sometimes you can deal with the infections effectively and not exacerbate the underlying lung disease. It is a very common -- but it very commonly is the inflammation of a viral or a bacterial process which will set up a vicious cycling of inflammation, mucous secretion and reinfection of the mucous to cause further inflammation of the lungs which leads to edema of the walls, secretion of mucous to plug the airways, and spasm of the muscles around the airways causing asthma-like attacks.
If it is truly pneumonia, the process involved includes inflammatory exudates and secretions, not only of the airways itself, but will actually involve the alveoli, the gas exchange units of the lungs themselves, and will cause what we call a consolidation picture where you have proteinaceous material, influx of

leukocytes in an attempt to fight off the bacterial or the infectious process.
And the recruitment of leukocytes in the process of pneumonia can, in someone who has underlying lung disease, can help perpetrate -- or perpetuate and cause the decompression of an underlying lung disease itself.
Q. What kinds of questions would you customarily ask a patient such as Mr. Eastman the first time you met him about his prior history of respiratory complaints, if any?
A. You do ask about a smoking history when someone present with respiratory problems. You ask a history about childhood asthma, a history as far as exposure to other potential processes that can chronically affect the lungs, such as asbestos or tuberculosis. Sometimes you'll ask about family history

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of asthma, since asthma does run in families and family members of asthmatics have a higher incidence of asthma themselves.

Depending on the circumstances in the radiographic picture, sometimes you ask about occupational exposure of things other than asbestos. That's usually when I have a stronger suspicion of occupational lung disease. I did not ask Mr. Eastman

anything about asbestos as far as occupational exposure.

Q. Did you ask him a question about his prior symptoms, such as -- other than for the two-week period before he presented to the hospital on June 10th, 1995, did you ask Mr. Eastman whether or not he had a prior history of shortness of breath or chronic productive cough or things along those lines?

A. Frequently I will at some point. I can probably assure you that in the emergency room at that point in time I was probably focused in on the problem he was there for and probably did not ask about previous symptoms, at least at the time in the emergency room.

Q. If Mr. Eastman reported to you a positive history of a productive cough or any kind of cough or respiratory symptom that had been present over a substantial period of time, is that something you would document?

A. If I had asked him that question and it appeared to be pertinent to his presentation, yes.

The one question I'm certain I did ask him was had anybody -- did he have any known history of lung disease prior to the admission, and he said no, he did not have any known history?

But in saying that, just to a patient that often means did a doctor ever tell you you had lung

problems, and no one ever told him that.

I do not believe, in looking at the records, I have not documented whether I questioned him about symptoms, prolonged symptoms, chronic symptoms prior to his presentation. I can virtually be certain in the emergency room just in the nature of how you evaluate patients in the emergency room, I probably did not get into that detail of a history with -- of it with him at that time.

Q. What significance would a prior history or the lack of a prior history of those kinds of respiratory complaints be to your development of a differential diagnosis of Mr. Eastman's condition?

A. The presence of those types of symptoms would make me more suspicious that he had chronic underlying lung disease that was in current exacerbation, more so than just an acute process in and of itself.

Q. Would the absence of a history like that be of significance to you?

A. The absence of prior symptoms does not exclude the absence of prior disease. So it would be worth noting that he had no such symptoms, but does not necessarily rule out any of the things that I would place in my differential diagnosis.

Q. Would it increase your suspicion of the impact

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of the acute process being a contributor to the symptoms that he presented with?

A. It would make me more suspicious that the majority of the problems were related to the acute illness.

Q. What questions would you have asked Mr. Eastman with respect to his prior use of alcohol?

A. That is generally part of my routine questions on the initial contact I've had with the patient.

Q. What would you ask?

A. Does he currently drink alcohol. If he currently drinks alcohol, how much he drinks, how frequently. And I do ask, you know, if he says he does not drink alcohol, I will ask have you never drank alcohol. Because that usually indicates either people have a strong religious conviction or they have had problems with it in the past if they are adamant about complete abstinence.

Q. Would a history of significant daily use of alcohol be relevant to your development of a treatment plan?

A. For pneumonia, if it's a significant pattern of alcohol abuse, that does lead to increased concerns of aspiration, leading to pneumonia, as far as drinking yourself to unconsciousness and possibly vomiting and

aspirating stomach contents.

There's also a significant increased risk of alcohol withdrawal and alcohol withdrawal seizures which can cause -- lead to pneumonias. But the biggest aspects of a -- when you're hospitalizing a patient who has had a significant daily use of alcohol is you have to watch for signs and symptoms of alcohol withdrawal as a complicating factor of the hospitalization, no matter what the reasons -- no matter what the reason they are being admitted for.

Q. Dr. Tinsley, did you note Mr. Eastman's prior history of testicular cancer?

A. Yes, I did.

Q. Did you develop a treatment plan for Mr. Eastman after you assessed his condition on June 10th, 1995?

A. Yes I did.

Q. And what was your treatment plan?

A. The initial treatment plan was to treat him with intravenous antibiotics with the type of antibiotics that would typically treat the majority of the community-acquired pneumonias that you would see walking in the emergency room, particularly in a smoker.

He did not appear to have bronchospasm, so we were treating him with inhaled bronchodilators that

would help both with the bronchospasm and with mobilization of secretions. And -- are you talking about just the first day I saw him?

(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)

MR. ACOSTA: I think it said he did appear to have some bronchospasm.

MR. DENSON: Oh, I'm sorry.

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(Whereupon, the reading of the deposition continued, as follows:)

A. He did appear to have bronchospasm, so we were treating him with inhaled bronchodilators that would help him both with the bronchospasm and the mobilization of secretions. And -- are you talking about just the first day I saw him?

Q. Yeah, what was the treatment plan that you identified on the first day?

A. The first day was antibiotics, Albuterol and hydration. But although not stated, the plan was to further assess him for signs of chronic lung disease, depending on his response to therapy.

Q. Did you have a discussion with him about his tobacco use on the first day that you saw him?

A. I cannot swear I talked to him about it the first day I saw him, no.

Q. I'm looking at page 25 in the chart, and I see a reference under activities to he was told to avoid tobacco use at all costs. Do you see that?

A. Page 25?

Q. Yes.

A. Yes.

Q. Do you see anywhere else in the chart in your progress notes, for example, that identifies anything else about the conversation that you had with Mr. Eastman about tobacco?

A. There's nothing documented in the progress notes when I may have had that conversation with him.

Q. I don't want to be redundant, but is there anything in looking at the chart that you would have told him in particular with respect to advice on smoking and health and cessation?

A. It's not documented in the chart, but I can assure you that within the first 48 hours of his admission that I would have discussed with him the amount of tobacco he was smoking, that it was adversely affecting his health, and it may have contributed to even catching the pneumonia. And then he would be advised to reduce and discontinue did it.

Prior to his discharge we did do pulmonary function testing and -- that did document he did have

obstructive lung disease, which is correlated highly with the use of tobacco smoke?

And I can tell you certainly --

(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)

MR. DENSON: Excuse me.

(Whereupon, the reading of the deposition continued, as follows:)

A. And I certainly -- and I can certainly tell you after seeing a pulmonary function tests I would have more vigorously, and I'm certain I did more vigorously instruct him that the smoking had already impacted upon his health and that discontinuing his tobacco use was imperative for his health and well-being given the impact it had already had on his pulmonary function.

Q. How would you characterize the results of the pulmonary function tests in simple terms that the jury

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can understand?
A. We would call it a severe obstructive ventilatory defect, which means that he has an obstruction to air flow on exhalation.
It falls in the severe category to make it a point that his functional capacity at the time he was being tested showed his ability to expel air from his lungs were only one -- approximately one-third of what

would be predicted for a man his age and his weight, that these findings are consistent with chronic obstructive pulmonary disease, which is the most common form of lung disease associated with smoking cigarettes.
Q. And directing your attention to page 34 in the chart, I see it looks like, I think that's an order at the bottom of the page related to respiratory therapy instructions?
A. Yes.
Q. What does that refer to?
A. You're you talking about the first one under 6/20/95? DC home, discharge home.
Q. I'm looking at the second one with respect to the part that talks about respiratory therapy instructions.
A. Oh. Change his nebulizer, which is a passive method of administration of medication, over to an MDI, a metered-dose inhaler, where it's just self-administered by the patient, whereas the nebulizer treatment you just put in your mouth and breathe deeply. The metered does inhaler takes some coordination and specific breathing instructions to take it appropriately?
So I was asking respiratory therapy -- I was changing him from the nebulizer to that metered-dose

inhaler, to come in and instruct him on the appropriate techniques so that he could get maximum medical benefit.
Q. And the documentation here just confirms that that's been done with Mr. Eastman?
A. I have to find the respiratory therapy notes. I don't see documentation by them that they gave him the instructions.
Q. Which form are you looking at there?
A. I'm looking at, like, 74, 75 and 76. These are the nursing forms. At some point I know that --
Q. Looking at page 76, let's take a look at that.
A. Okay.
Q. Up at the top with respect to educational assessment, what box is checked?
A. Okay. This is the generic teaching plan per the nurses. Now, are you talking about page 76?
Q. Right.
A. They say the patients was eager to learn, his knowledge appeared adequate, there's no barrier to learning, and there was no cultural or religious beliefs that would affect the education plan.
Q. While we have the nursing assessment out, can you take a look at page 71 there as well. And in section G, what does that reflect there with respect to Mr. Eastman's tobacco habit?

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A. He said he was -- he said he was currently smoking and he states that he's going to quit his tobacco use.
Q. What does it state there with respect to his use of alcohol?
A. Beer only.
Q. In a patient such as Mr. Eastman, when giving him advice at the time of discharge regarding his lifestyle in addition to suggesting that he quit smoking, did you make any suggestions with regard to his use of alcohol?
A. I did not. I would if a patient seemed to be drinking an excessive amount or it -- or may be impacting adversely on his health.
Q. And how would you make that determination?
A. First off, if he has any disease process that's affected by alcohol use, and also it depends on the quantity and frequency of drinking.
Q. Did you have a habit in practice of instructing the patients under your care with respect to the importance of the use of their inhalers?
A. Yes.
Q. Can you, and again, in lay terms, describe what your custom, habit and practice was at the time that you treated Mr. Eastman when instructing him

regarding the use of inhalers.
(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)
MR. ACOSTA: Oh, it was them. I'm sorry.
(Whereupon, the reading of the deposition continued, as follows:)
A. If not in the hospital, if I'm initiating therapy in my office, I go over the appropriate techniques of using the inhaler. If you're using the inhaler for chronic obstructive pulmonary disease and not asthma, it also depends upon the severity of the disease, but that continuing use and daily use and the appropriate frequency of use can help maintain a patient in their best functional status with minimizing of symptoms to the best degree, depending on the patient's underlying disease status.
At the lesser diseases, at the milder diseases, at times you can instruct the patient that they can use it just as needed. But on the more severe diseases, the habit of using it as instructed can lead to maintenance of a better quality of life and actually may decrease the frequency of recurrent infections and exacerbation by maintaining their airways and keeping their lungs in optimal status.
Q. So in a patient such as Mr. Eastman, who you

determined had a severe COPD, what would you have said to him?
A. I told him that medical appliances is impaired it, to take the medicines as instructed at the routine that we instructed them. I would tell him to cease smoking. I would tell him that he needs a yearly flu vaccine as a preventative measure and that probably a pneumococcal vaccine would be of benefit, and that

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seeking of early medical intervention at the earliest signs of infection would help prevent the need for hospitalization and make us able to treat an exacerbation before it became severe enough to require hospitalization.

Q. If a patient requested your assistance in quitting smoking, is that something you would have a habit of documenting?

A. If he had requested assistance in discontinuation of tobacco, yes.

Q. And did you see anything where you determined that Mr. Eastman asked for your assistance in quitting smoking.

(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)

MS. FAGGIANELLI: It should be documented.

MR. ACOSTA: Well, there's two questions here.

Let me just read the second question --

MR. DENSON: Okay.

MR. ACOSTA: -- since there's no answer to the first question.

(Whereupon, the reading of the deposition continued, as follows:)

Q. As you're looking at your chart, I guess what would you put in your chart? What would you write down?

A. Well, if the patient had asked to discontinue his tobacco use, I would ask -- I would probably -- I would state that the patient is having difficulty stopping on his own and I would document the medications or referrals that I made in regard to that.

Q. And that sort of documentation's part of your custom, habit and routine during the time period that you were treating Mr. Eastman?

A. Yes.

Q. And feel free to look at the medical record or the office chart you have there, but do you see any indication in the medical record or your hospital chart that you wrote down what you've just described you would typically write down if a patient asks for your assistance in quitting?

A. I don't see any documentation that anything was prescribed specifically to assist him in his

discontinuation of tobacco use. He was prescribed Zoloft, but according to the records, his wife had reported to me that she felt he was suffering from depression and I chose Zoloft because sometimes the antianxiety --

(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)

MR. DENSON: Excuse me.

(Whereupon, the reading of the deposition continued, as follows:)

A. And I chose Zoloft because sometimes the antianxiety properties of that can help ease the nicotine craving or the anxiety that occurs when people are often going through nicotine withdrawal, is the reason I chose that particular one. But the reason for administration was not at the patient request, but at the wife's request that she felt he was having

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depression.
Q. If a patient was experiencing anxiety or withdrawal symptoms, is that something you would make a practice to document as part of your clinical documentation?
A. Yes.
Q. And as of the prescription for Zoloft that you see in the chart made at the request of Mr. Eastman's

wife, do you see any documentation by you of clinical signs or symptoms of withdrawal?
A. There's nothing documented in the hospital records.
Q. Did you see Mr. Eastman again after he was discharged from the hospital?
A. Yes.
Q. And on -- what was the first date that you saw Mr. Eastman?
A. July 6th of 1995.
Q. Did you make any record in your office chart here that identified a particular clinical problem that Mr. Eastman expressed to you as being related to a difficulty in quitting smoking?
A. He did not report to me any difficulty in discontinuing his tobacco use.
Q. Having seen Mr. Eastman on two occasions in July of '95 and August of '95, would it have been your custom, habit and practice to discuss with him the importance of the use of his inhaler regimen?
A. Yes. I would have instructed him to continue to be compliant with his inhaler regimen.
Q. If Mr. Eastman had reported to you that he had some difficulty understanding how to use them or why to use them, and would that be something that you would

document in your chart?
A. Yes.
Q. Do you see any sign of that documentation in your chart?
A. I did not see him expressing any questions about the use of the inhalers. My nurse does document that he was using the inhalers less than the prescribed amount.
Q. Upon seeing that documentation, would you have a conversation with the patient about the importance of complying?
A. Yes.
Q. What would you say?
A. I would say that he needs to take the medication as prescribed. It would be to his benefits and help prevent exacerbations of his underlying lung disease.
Q. Did you -- did you ask Mr. Eastman to return to you for further care and treatment?
A. Yes.
Q. When did you ask him to return?
A. In one month.
Q. Did Mr. Eastman ever return to you?
A. No, he did not.
Q. I'm going to tender to you a document entitled

http://legacy.library.ucsf.edu/tid/bhq37a00/pdf
Support http://www.industrydocuments.ucsf.edu/docs/zfjl0001

Clinics in Chest Medicine and ask that you identify it for the record.

A. It's Clinics and Chest Medicine, Smoking and Pulmonary Vascular Diseases, Volume 21, Number 1, March 2000.

Q. Does the section of pulmonary and critical care associated with the university -- the Yale University School of Medicine enjoy a good reputation in the medical community?

A. Yes.

Q. With what -- with respect to the topic of smoking and chronic obstructive pulmonary disease, would this be a reference source such that pulmonologists, internists, and critical care specialists would refer to when they were looking for information on smoking and chronic obstructive pulmonary disease?

A. Yes.

Q. And it would be reasonable to do that?

A. Yes.

Q. There would be no basis, looking at what you see identified here, to exclude this from the reasonable sources of medical information about smoking and chronic obstructive pulmonary disease, would there?

A. No reason to exclude?

Q. Yeah, no reason to exclude this from your

review?

A. No, I would not exclude this from my review.

Q. One question about this. Turn to page 69 to 70. And it goes to the bottom right-hand column to the top of the next page. Can you read the sentence that begins at the bottom right-hand column?

A. Intriguingly, three studies have implicated alcoholic consumption as a risk factor for COPD.

Q. Can you continue to the next?

A. One study found former alcohols to have a higher prevalence of air flow obstruction. And in the Tucson study alcohol proved to be a significant predictor of lung function after controlling for smoking.

Q. In your own personal experience, have you treated patients with COPD and who have a history of excessive alcohol consumption?

A. Yes.

Q. Do you advise them as a matter of routine habit, custom to stop drinking alcohol as well if they are continuing to drink alcohol in an excessive amount while they have COPD?

A. If people appear to be drinking alcohol in an excessive amount that is compromising their health, yes, I advice them to discontinue their tobacco use -- their

alcohol use.

Q. First I would like to ask you, we're here in your office in Clearwater; is that right?

A. That's correct.

Q. And what hospitals in the local area here are you on staff or which hospitals do you have privileges to practice?

A. Morton Plant Hospital, Largo Medical Center,

http://legacy.library.ucsf.edu/tid/bht07a00/pdf Courtesy of http://tobaccoindustrydocuments.ucsf.edu/docs/zfjl0001

Suncoast Hospital, and HealthSouth Rehabilitation Center.

Q. And do you see patients on a daily basis?

A. Yes.

Q. And do you have rounds that you make at the hospitals?

A. Yes.

Q. And as I understand it, about 45 percent of your patients are lung patients that deal with lung diseases --

A. Yes.

Q. -- of one kind or another?

A. Yes.

Q. And that would include lung cancer?

A. Yes.

Q. And emphysema?

A. Yes.

Q. And chronic bronchitis?

A. Yes.

Q. Asthma and lots of other kinds of diseases?

A. Yes.

Q. And you've indicated that you plan to recertify yourself in that subspecialty of internal medicine within the next year?

A. Recertify in the specialty of pulmonary medicine, yes.

Q. In terms of emphysema, can you tell us what kind of a disease that is?

A. It's considered a disease of obstruction to air flow. Nowadays we combine the diagnoses of emphysema with chronic bronchitis under a unified term COPD, chronic obstructive pulmonary disease, because no one has truly just emphysema or just chronic bronchitis. Everybody has a mixed pattern?

But specifically emphysema involves the destruction of the air exchange units such that you have large cavitary lesions within the lung where there's absence of functional lung tissue which leads to the potentially low oxygen units, but more specifically because of decreased tethering of the airways opened by the elasticity of the lung which is lost with the destruction of the tissue, the airways tend to close

prematurely on exhalation.

Q. Can you describe what air trapping is?

A. Air trapping is when you have what we consider an elevated residual volume, which is the amount of air that's left in the lung after a forced expiration such that a person cannot expel the total amount of air that he normally would be able to do in someone usually of his age, weight, and sex, that this decrease in the ability to expel the normal amount of air leads to an elevated amount that is left in the lung after a complete forced exhalation.

Q. When a person who has a chronic obstructive pulmonary disease inhales material, you know, in the form of smoke or dust or anything like that, are they more likely to stay to stay in the lung?

A. It depends on the chronic and the continuous nature of the exposure. Inhaled materials tend to stay

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in the lung longer than someone with normal lungs.
Q. What is the reason for that?
A. Well, it depends on the degree of inhalation. Again, if you have the phenomenon which we call air trapping and premature closure of the airways such that you do not necessarily have a complete emptying of all the air pockets within the lung with every exhalation, that there is a, basically what we call air trapping.

Because of -- because of some of those premature, you don't always -- it takes longer to equilibrate the inhaled materials with the external air and, therefore, they are left in there longer than someone without the disease process.
Q. Aside from the air trapping, is there a mechanism within the lungs that helps the lung to clean itself?
A. Well, there's the mucous production itself, so that the -- if there's a particulate matter, the mucous will entrap some of this particulate matter, which would also hold it in the air longer.
(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)
MR. DENSON: Excuse me.
(Whereupon, the reading of the deposition continued, as follows:)
A. Then there's what we call the cilia within the lung which move trapped material out which is typically impaired in people with these disease processes.
Q. What is the -- what does the cilia look like?
A. They are frequently described on microscopic analysis as either little hairlike or fingerlike projections that move in a considered manner to move things out of the lung to the upper airways for

expectoration.
Q. Or swallowing?
A. Or swallowing, yes.
Q. And does cigarette smoke have an effect on the cilia and the mucous flow in the lung?
A. It increases mucous flow as far as mucous production, but decreases the ability to clear this mucous. The cilia, the initial stages are paralyzed with the initial exposure to tobacco. With chronic exposure the cilia become blunted and even lost and denuded.
Q. What effect does the paralysis of the cilia and the increased mucous flow have on the ability of the lung to clean itself?
A. Well, without the ability to clear the secretions, the secretions stay in the lungs longer. And the secretions themselves are proteins and sugars which are a media for bacterial growth.
Q. On the subject of cigarette smoking, you indicated that you generally advise your patients that they should not smoke; is that fair?
A. Yes.
Q. And, of course, patients that come to you with lung diseases that smoke you are more emphatic with?
A. Correct.

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Q. What percentage of your patients have chronic obstructive pulmonary disease, either chronic bronchitis or emphysema or a mixture of the two and are cigarette smokers?
A. You mean currently or have been?
Q. Say in the last ten to 13 years, since 1990.
A. I mean, that's what I'm asking you. Are you asking me were they -- have they ever smoked cigarettes or do they still smoke at the current time of the disease?
Q. Current or former. Both.
A. I would say people with COPD, I would say at least -- it would be greater than 90 percent, probably in the range of 95 percent are smokers or previous smokers.
Q. My question is limited simply to when a person comes to you for the first time and is diagnosed with COPD. How many of those people are current smokers or smokers at the time you make the diagnosis?
A. Probably about 50 percent or maybe a little bit more.
Q. And you indicated, I believe, when you were questioned earlier that you tried to get them to I didn't tell smoking if possible. And my question is what did you mean by, quote, if possible, end quote?

A. Not every patient who wants to discontinue smoking, and even the patients who want to discontinue smoking, not every patient is able to discontinue tobacco use.
Q. Those that want to quit smoking that are unable, is there a physiological -- a physiologic basis for their inability to quit smoking, to your knowledge?
A. There is proposed both physiologic and behavior problems with their continued -- discontinuation of smoking.
Q. When you say proposed, what do you mean by that?
A. I don't know that one study has shown a specific enzyme pathway or physiologic change that makes the patient dependent on nicotine or tobacco smoke.
There are a lot of studies looking at behavioral aspects of people smoking and physiologic changes in people going through nicotine withdrawal that propose that there is in some people, not all people, an addictive reaction to nicotine or to other aspects of tobacco smoke that do make certain patients addicted to the tobacco smoke.
Q. Is nicotine dependence or addiction to cigarettes something that influences the behavior of the smoker?

A. Yes.
Q. In what manner does it influence the behavior of the smoker, based upon your knowledge and background and care?
A. Again, even when a patient is aware the smoking is having an adverse health consequences, that they continue to smoke. In their efforts to discontinue smoke, they oftentimes become agitated, moody,

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depressed.
Q. When do those symptoms of agitation or moodiness or depression, when do you -- when do those usually occur after a person has had his last cigarette?
A. It depends on how frequently and how much that person smoked.
Q. Let's assume that it's, you know, a one to two-pack-a-day smoker. How soon after the last cigarette would they experience withdrawal symptoms, as you describe them?
A. It could be within 30 minutes to an hour, hour and a half. It's been shown that patients who smoke cigarettes smoke to attain a certain nicotine level in their blood. Now, when that level drops below their preset level, they do start experiencing the cravings and signs and symptoms of nicotine withdrawal.
Q. And then how long usually do the withdrawal

symptoms last?
A. Variable. I've had some patients say that they continue to crave and want cigarettes for years after their last cigarette. You do not have the -- you do have the occasional patient who obviously did not have a nicotine addiction despite a significant smoking history who said, I put the pack of cigarettes down and never looked back.
But the acute rise in heart rate, rise of blood pressure, tremulousness sometimes can last, the physiologic changes can last for weeks and weeks after the last cigarette. The craving, though, can last for years.
Q. All right. In terms of the acute withdrawal symptoms such as irritability, anxiety, jitteriness or nervousness, how long do those usually last?
A. Usually days to week.
Q. Now, in Mr. Eastman's case, he was hospitalized on June 10th. Do you know when he had his last cigarette?
A. When he was admitted, he had told me he had been continuing to smoke, but I don't know when his last cigarette was as far as in relationship to his admission. I can't tell you if it was that day or days before that he had had his last cigarette.

Q. Now, when he was in the hospital, was he admitted immediately from the emergency room?
A. Yes, he was.
Q. And what was the reason he was admitted immediately from the emergency room?
A. Because he had evidence of pneumonia and he had low oxygen levels.
Q. And you used the term hypoxic previously?
A. Yes.
Q. In lay terms, what does that mean?
A. Low oxygen levels.
Q. And what effect does that have on a person to have a low oxygen level like his?
A. It depends on the degree of the low oxygen level. The first arterial blood glass we had was on four liters per minute, which had corrected that?
But hypoxic levels of 85 to 90 percent

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saturation of oxygen has little effects. Oxygen levels below that, 80, 85 percent, people oftentimes will feel short of breath. And in chronic long-term, you start finding the chronic long side effects of hypoxia.

It depends on the rapidity of onset of the symptoms. There are some patients who have had a chronic low level of oxygen that has been gradually progressive who have low oxygen levels that would make a

person unconscious if it happened acutely, but because their body has had time to compensate for it, they can walk into the emergency room and look normal yet have an oxygen level that sometimes we feel is incompatible with consciousness.

But if you start getting saturations particularly below 80, 75 percent, you can start seeing agitations -- agitation, sometimes lethargy, again disorientation, confusion, weakness, difficulty ambulating. So acutely low oxygen levels can be quite significant and lead to unconsciousness even.

Q. At what level was Mr. Eastman's when --

A. I don't know what level it was because he first -- because the first arterial blood gas that we did, we had him on four liters per -- four liters per minute oxygen.

Typically inspired oxygen is 21 percent. Four liters would be approximately anywhere from 36 to 40 percent oxygen, so almost double the amount of oxygen that you or I would have. And it raised his oxygen level to a normal level, but I don't know what it was when he walked in the door. I just don't have that information.

Q. Was he put in a room and put in bed essentially?

A. Yes.

Q. And I believe you said he was given intravenous IVs, which were both to hydrate him and to give him -- to hydrate him to give him body fluids?

A. Correct.

Q. And another for antibiotics?

A. Correct.

Q. And was he also given other medications while he was in the hospital?

A. He was eventually started on intravenous steroids. He was started on aminophylline.

Q. And what does aminophylline do?

A. It works as a bronchodilator. It has several physiologic effects that can be useful in the treatment of someone with chronic obstructive pulmonary disease.

Q. And any other medications that he was put on?

A. Just, again, the Zoloft that we mentioned earlier, the aminophylline products, the antibiotics, and the inhaled bronchodilators.

Q. Now, when John Eastman was in the hospital he had -- did he wear an oxygen mask?

A. We gave him what we call nasal cannula oxygen, which is the prongs in the nose which supply the oxygen.

Q. Was Mr. Eastman permitted to smoke in the hospital?

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A. If a patient is alert and oriented, we cannot restrict a patient from smoking. They are not allowed to smoke in the hospital, but there is a smoking area outside the hospital.
Q. Well, let me ask you. Did he have a portable oxygen system in the hospital, or was it some other system?
A. To my knowledge in the hospital he only had the wall attachment.
Q. And was he on oxygen 24 hours?
A. Twenty-four hours a day while in the hospital except maybe just for very brief periods of coming off.
Q. And was he permitted to leave his room?
A. Again, we can't restrict a patient who's alert and oriented from doing things. So he could have walked out of the room. We discouraged it. We discourage them from leaving the floors. To my knowledge, he didn't leave the floor.
Q. To your knowledge, was he in and out of bed during that time?
A. We try not to restrict the --
(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)
MR. DENSON: Excuse me.
(Whereupon, the reading of the deposition

continued, as follows:)
A. We try not to restrict the patient to bedrest. We want them to be up and moving around.
Q. When he left the hospital, he was on portable oxygen at that time?
A. He would have a home-based unit and did have a portable -- and did have portable oxygen at home, yes.
Q. And how long -- how long was he on that before you said he could go off the oxygen?
A. He was discharged on the 20th, and he was given instruction on July 11th that he could discontinue the oxygen. So that would be about three weeks.
Q. And was he on other medications upon discharge?
A. He remained on TheoDur, Zoloft. He was weaned down and off the prednisone. He was on the inhaled bronchodilators along with a sleeping pill, which was ProSom.
Q. And what was the purpose of the bronchodilators?
A. Again, to decrease the spasm of the airways, to open the airways up and ease the air flow of the lungs.
Q. Was it to help him breathe?
A. Yeah.

Q. Did pneumonia resolve itself?
A. Yes.
Q. Now, you indicated that for patients that you have advised to quit smoking that you would discuss with them strategies if either they asked for it or you wanted -- under what circumstances would you give them strategies?
A. If a patient stated they had the desire to

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stop smoking but were unable to do so, I would discuss various strategies that were available to a patient.

Q. Okay. And what -- why are strategies needed?

A. Because the -- for tobacco smoking, there's both a behavioral aspect and a psychologic aspect of the desire --

(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)

MR. ACOSTA: It's physiological.

MR. DENSON: Oh, excuse me, physiologic.

(Whereupon, the reading of the deposition continued, as follows:)

A. There's a behavioral aspect and a physiologic aspect of the desire to keep smoking. So you have to tailor something to both deal with what we consider the chemical addiction and also the behavioral problems.

Q. If Mr. Eastman was on Zoloft for whatever

reason while he was in the hospital, would that reduce the anxiety that may accompany withdrawal from cigarettes?

A. Zoloft was given both for anxiety and depression. The hope was that the Zoloft would reduce any anxiety resulting from the nicotine withdrawal, although I don't know of any study that shows Zoloft is useful as far as an aide in discontinuation of tobacco use.

We do frequently use many antianxiety medicines that haven't been definitely shown to help people stop smoking either.

Q. Is there generally a dose response to nicotine in cigarettes?

A. There's a dose response to the health issues involved as far as the degree of tobacco use and longevity of tobacco use, there's a definite dose response relationship.

Again, people do -- it's been shown on numerous occasions that people smoke to maintain a level of nicotine in their bloodstream, and for those people, yes, there seems to be a dose response. If they smoke less than the amount to achieve that nicotine level, they have a physiologic response.

Q. And are there nicotinic receptors in the

central nervous symptoms?

A. Yes.

Q. What are they?

A. There are various neuro transmitters used in different pathways in the brain. Again, certain ones which we call nicotinic we know definitely respond to the effect of nicotine. There's other forms we call muscar- --

(Whereupon, there was an interruption in the reading of the deposition testimony, as follows:)

MR. ACOSTA: Muscarinic.

(Whereupon, the reading of the deposition continued, as follows:)

Q. -- (continuing) muscarinic that again respond to different type of chemical structures.

Again, we do have pathways called the nicotinic pathways in the brain, although I can't really

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tell you exactly what these pathways are involved as far as the physiologic -- physiology that they control.

MR. ACOSTA: Your Honor, might this be a good time for us to --

THE COURT: Okay. I was hoping that it was. All right. We'll take a 15-minute afternoon recess.

THE BAILIFF: All rise. Court's in recess for

15 minutes.

(Whereupon, a brief recess was taken, after which the following proceedings transpired:)

THE COURT: Mr. Acosta.

MR. ACOSTA: Yes, sir.

THE COURT: How much longer?

MR. ACOSTA: I'm guessing about 20 minutes on this one.

THE COURT: On yours?

MR. ACOSTA: Of the whole thing. I read theirs after all because it was bad enough the way it was, but it would have been even worse. I made the decision to do it. I told her I was going to do it. She did have an objection she wanted to raise.

THE COURT: I just told the sheriff to bring the jury in.

MR. DENSON: It's for the next one.

MR. ACOSTA: The next one we are going to try to do the sound, so... The next one is about 45 minutes, so that will take us pretty close to -- depending on how much they want to read. That one is my cross on video, so there won't be anything to add to that.

THE COURT: All right. Let's proceed.

MR. ACOSTA: May it please the Court. Page 111.

(Whereupon, the continuation of the deposition testimony of Steven B. Tinsley, M.D. was read to the jury, with Mr. Acosta reading the questions and Mr. Denson reading the answers, as follows.)

BY MR. ACOSTA:

Q. I believe you said that he had an early right lower lobe infiltrate.

A. Right.

Q. What does that mean?

A. It's a radiographic evidence, an x-ray evidence of changes in the lung that would suggest infection.

Q. I believe you said he had rales in the right base. That would mean that you listened to both sides of his chest but he only had them on one side?

A. Correct.

Q. And are rales a sound that's heard when you put a stethoscope on the chest?

A. Yes, it is.

Q. And is it a sound that's specific to the opening and closing of the airways? I mean, the air sacks. I'm sorry.

A. That's the general belief, but it has to do

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with the opening and closing of the alveoli.
Q. Well, let me ask it. Just based on your assessment, did he have wet or dry rales?
A. I would say wet.
Q. And would wet rales be consistent with the infiltrate of fluid in his lung?
A. It would be more suggestive of that, yes.
Q. Are those things what primarily led you to diagnose a pneumonia?
A. Yes.
Q. Now, are smokers more likely to get pneumonia than nonsmokers?
A. Yes.
Q. Why is that?
A. Because the contents of tobacco smoke actually inhibits the inflammatory process.
(Whereupon, there was an interruption in the reading the deposition testimony, as follows:)
MR. ACOSTA: No. Response.
MR. DENSON: Excuse me.
(Whereupon, the reading of the deposition continued, as follows:)
A. Because the contents of tobacco smoke actually inhibits the inflammatory response and inhibits the immune response to infection. It has been shown to

paralyze the macrophages and the polymorphonuclear leukocytes, the white cells that are involved in combating infection. Also, it helps -- it does decrease the lung's defenses again infection as we talked about inhibiting the ability to clear secretions, paralyzing the cilia within the lung, or making the cilia dysfunctional as part of the airway defenses. So it inhibits the airway defenses, the lung's defenses against infection.
Q. Now, you were asked some questions about alcohol. And if a person who's an alcoholic or has difficulty with his consumption of alcohol and is hospitalized for pneumonia or for anything else, is the alcoholism something that's taken into account when the patient is in the hospital?
A. Yes.
Q. And why is that?
A. Well, again, when a patient is hospitalized, we don't supply them alcohol. So if they are alcohol dependent, then there's the chance they may go through alcohol withdrawal within the hospital, which we like to be aware so we can treat it appropriately and hopefully prevent some of the complications of alcohol withdrawal.
Also, people who are alcoholics tend to be malnourished, then to be noncompliant with medical

therapy, so -- and also alcohol itself has adverse health issues which may or may not be related to the reason the patient is in the hospital.
Q. Did Mr. Eastman present with any signs of alcohol abuse?
A. No.
Q. And of course he didn't have any symptoms of alcohol abuse, did he?

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A. Not to my knowledge, no.
Q. And the history that was given regarding his consumption of alcoholic beverages was what?
A. He drank beer occasionally.
Q. Did you think that Mr. Eastman's lung condition could have --
(Whereupon, there was an interruption in the reading the deposition testimony, as follows:)
MR. ACOSTA: Excuse me. I need to strike that. We're going to have to skip to 118, line -- I want to just leave it in.
(Whereupon, the reading the deposition testimony continues, as follows:)
Q. Did you think that Mr. Eastman's lung condition could have been related to radiation exposure?
A. The spirometry that was performed was inconsistent with damage from radiation exposure.

Q. And was it consistent with something else then?
A. It was consistent with obstructive lung disease, the COPD.
Q. Let me ask you, do you have an opinion within a reasonable degree of medical probability as to whether or not Mr. Eastman's smoking history was causative in his COPD?
A. The tobacco use would be the number one instigating factor in his lung disease.
Q. Why is it that people can have moderate to severe COPD, either emphysema, chronic bronchitis or both, and not have any symptoms until it reaches a certain point?
A. Because as with many organs in the body, there's a definite reserve capacity that's available to a person. Again, it depends on how much of that reserve they use. As an analogy I use, where they are a professional sprinter, obviously they need more reserve than someone who sits at a computer terminal. Therefore, people who use less of their reserve will not notice any symptoms until all of their reserve is gone and now it's impeding on their functional amount, functional lung capacity they use in their everyday life.

Q. Page 60. Let's look at this. Look at page 60 zero of your records there and tell me what Mr. Eastman's predicted forced vital capacity was?
A. 4.5 liters is the total amount of air he should be able to expire with the maximal inspiration, and to maximally expire would be 4.5 liters. The FEV1 would be three and a half liters as far as his predicted value.
Q. Approximately how much of what he should have been able to expire was he able to expire?
A. In one second he was only able to expire 35 percent of what he should -- of what should have.
In one second he was only able to expire 35 percent of what would have been predicted for him.
Q. So that's about one-third?
A. About one-third, yes.
Q. Now, you mentioned emphysema a minute ago. Is

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the destruction -- and you mentioned the destruction. The tissue is destroyed in that process?
A. Yes, it is.
Q. Is it curable?
A. By medical science, no. At its current stages, no.
Q. And you were asked some questions regarding his use of medications at the time he got out of the

hospital. Do you recall that?
A. Yes.
Q. You mentioned something called a nebulizer. What is a nebulizer?
A. A nebulizer is what he was using in the hospital. That's when you put the medicine directly in a container that has forced air through it that all you have to do is passively breathe the medicine and it will be absorbed in the lungs.
Q. How often was a nebulizer used with Mr. Eastman while he was in the hospital?
A. A minimum of four times a day, but it could have been five to six times a day.
Q. And how long would he wear the mask to do that?
A. Ten minutes or so.
Q. And then when he got out of the hospital, instead of the nebulizer was he given something else?
A. It's called an MDI inhaler.
Q. How does that work?
A. It's a little pressurized container where you get a preset amount of medicine delivered. It's kind of like the Primatene Mist that you see that you have to coordinate your breathing with the activation of it, then you actually hold it into your lungs. You have to

hold your breathe for a period of time to increase the time the medicine is in contact with the lung itself.
Q. Okay. How big -- is there a little cylinder that it's attached to, maybe six or eight inches in size, or is it smaller than that?
A. There is a spacer that sometimes people will attach to it, but the MDI inhaler is typically about three inches long.
Q. Was given several different medicines that he had to inhale?
A. Two different medicines, Atrovent and Albuterol.
Q. And was he also given a steroid?
A. He was given oral prednisone.
Q. And that he had to be weaned off of?
A. Correct.
Q. And why do you have to wean someone off of Prednisone?
A. The only time you really have to wean someone off is when they've been on it for a prolong period of time to prevent withdrawal. In lung patients we tend to a slow wean because the patient -- if the patient is going to relapse, we hope to catch them when they're at a less severe state as you gradually step down their steroids on a day-by-day basis.

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So at least the philosophy is you gradually take them down. If they start to relapse at that 30 milligrams where they were on 60 milligrams, you can hold it there or increase it slightly and maintain them at a slightly longer period of time to increase the likelihood that they will recover.

Q. Is he given a dose -- excuse me. What did you give him in term of milligrams per day?

A. I would have to look at that.

Q. Is it somewhere in the range of five to 20?

A. No.

Q. Less than that?

A. No. Somewhere in the range of 40 to 60. I gave him 30 milligrams twice a days when he left, which is 60 milligrams a day.

Q. Is that a fairly strong dose?

A. Yes.

Q. Does prednisone cause a person to have any feelings, side-effect feelings?

A. There are many, many side effects, depending upon the dose and how long you are on it. Acutely in the short term it can increase the appetite and therefore increase weight gain and the retention of fluid. Psychologically, it can make them more agitated or make them depressed or give them difficulty sleeping.

It does have psychological effects. Long-term steroids, if you put people on it and do not remove, it has a tremendous amount of side effects.

Q. Now, the other medications that were given, such as though through the nebulizer while he was in the hospital, what kind of effect do they have?

A. They have very minimal effects. Some patients, since they are given an inhaler, the effects are predominantly local and sometimes they can make people kind of shaky and tremulous for a few, you know, five to ten minutes after the administration.

Q. Was he given something other than Zoloft to help him sleep?

A. He was given ProSom at some point to help him sleep, which is basically a sleeping aid. He was not given it -- from my notes, was not given it at the time of discharge but was given at it at a later time. I'm not sure if he contacted my office before he came in, but I don't have it dictated as one of the medicines I wrote a prescription for. But by the time he showed up to my office the first time, he was taking ProSom.

Q. Are boli a finding associated with emphysema on x-ray?

A. Yes.

Q. What are boli?

A. They are large areas of the lung that no longer have any lung tissue. It's kind of like an empty balloon.

Q. In reviewing the chest x-rays for Mr. Eastman's June 10, 1995 admission, was there evidence of boli that you either documented in the chart or that the reviewing radiologist documented in preparing the official radiology report?

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A. No.
Q. In your review of the June 10, 1995 radiology report, was there anything that you see in the official interpretation that would be a classic finding for emphysema?
A. No.
Q. Do you recall the series of questions that Mr. Acosta asked you about the effects of smoke on the cilia and the mucus production of the lungs?
A. Yes.
Q. If in fact smoking was having those effects in a particular individual smoker, what symptoms would you expect them to cause?
A. Well, the increase mucus production, increase cough production of phlegm, which would be white or discolored. Again, sometimes you would expect to see increased susceptibility to infection, some more

frequent exacerbations of acute bronchitis or even pneumonias.
Q. Over the course of a period of, say, five to ten years, if smoking was causing those kind of changes in a smoker, how would you characterize the expected clinical course with respect to the presence or absence of a cough, the presence or absence of a productive cough and symptoms of those or that nature?
A. Again, it depends upon the severity of the problem. If they have symptoms, which not everybody would. But if they had symptoms, it would probably be an increased frequency of a cough.
Q. Are you familiar with any study that shows that Zoloft actually has the effect of reducing the smoker's craving for nicotine?
A. No.
Q. Are you aware of any study that has shown any medical significance to the use of Zoloft that any significant association with the ability of smokers to quit?
A. No.
Q. You were asked about the single x-ray of Mr. Eastman's chest that was done back on June 10 or so of 95 and you were asked whether it demonstrated boli.
A. Yes, sir.

Q. Can you tell us what boli is?
A. Again, it's a large area of open lung that's really without any active lung tissue involved. So it's like a ballon, just an air-filled pocket within the lung.
Q. Are they always seen on x-ray?
A. No.
Q. So you can have boli without being able to see them on x-ray?
A. Boli is typically a radiographic description, so boli is typically what we describe radiographically rather than any way. But x-rays are insensitive and they may in the ability to detect -- are very insensitive to the ability to detect COPD.
Q. Can you or do you as a lung physician diagnose COPD, either chronic bronchitis or emphysema, from an x-ray of a lung?

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A. No.
Q. And what do you need? What's the diagnostic criteria for chronic bronchitis or emphysema?
A. The way to make that diagnosis is by a pulmonary function testing.
Q. Is that what you did in Mr. Eastman's case?
A. Yes.
Q. Are x-rays an insensitive tools for the

diagnosis of COPD?
A. Yes.
Q. Is emphysema actually a pathologic diagnosis?
A. Yes. It's a pathology diagnosis. We infer emphysema based on some x-ray, criteria some PFT criteria. But emphysema itself is truly a pathological diagnosis.
Q. And in this case, with respect to the x-ray criteria in which you have in front of you, those criteria don't exist in the x-ray, correct?
A. Correct.
(Whereupon, there was an interruption in the reading the deposition testimony, as follows:)
MR. DENSON: That's the end.
MR. ACOSTA: Well, no. There's some more.
Page 142.
(Whereupon, the reading of deposition testimony continued, as follows:)
Q. Is there such a thing as a clinical diagnosis of emphysema and COPD?
A. Yes.
Q. Can you distinguish that from a pathologic diagnosis?
A. Yes. Again pathologically speaking, you do. You do see the destruction of the lung tissue itself.

You can physically see it microscopically and sometimes on gross pathology.
Clinically, you're inferring that the destruction is there based upon the observed clinical effects or testing that you have done to support the changes in the physiology and function of a lung based upon the testing that you've done that would be explained by the pathology that would be seen at postmortem examination.
Q. Is the clinical diagnosis considered a standard in the medical profession?
A. Yes.
Q. And did you make a clinical diagnosis of Mr. Eastman's chronic obstructive pulmonary diagnose?
A. Yes.
Q. And was his chronic obstructive pulmonary disease of the type that has resulted from the destruction of his lung tissue?
A. I don't have enough, but you're talking about the gas exchange units. I don't have enough information. He had a COPD pattern. There are certain patterns that are more consistent with emphysema, but they require lung volumes and diffusing capacities -- diffusing capacity to make that type of assessment based upon.

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That's one reason as I -- when we started talking at the beginning, I said we know group emphysema and chronic bronchitis under one diagnosis for various reasons. But he fulfilled the diagnosis as COPD, which is the current thinking -- which the current thinking is if you got COPD, you have -- you both have evidence of pathologic diagnosis of both chronic bronchitis and emphysema because one does not exist by itself in the complete absence of the other.

Q. In Mr. Eastman's case then, based on the visits you had with them ten days in the hospital and then two follow-up visits, you didn't see or do any further testing which would distinguish between the two any further than what you've already testified about?

A. I've not seen any further testing. If he had continued to follow-up with me, at some point we would have repeat the pulmonary function test, because the ones that were done in the hospital were done in a fairly unstable, acutely ill state. And we would have liked to have seen what his baseline was and completed lung volume part of the pulmonary function test to further characterize his disease.

MR. ACOSTA: That ends Dr. Tinsley's deposition.

THE COURT: All right.

MR. ACOSTA: And next we're hoping for a video deposition of Dr. Bruchette.

MS. FAGGIANELLI: Your Honor, before we get started with that, there is one issue that --

THE COURT: Approach the bench.

(Whereupon, the following proceedings occurred out of the hearing of the jury:)

MS. FAGGIANELLI: Pages 115, 116 of Dr. Burchette's deposition, there's testimony about addiction and nicotine withdrawals. Dr. Burchett is a general practitioner, a primary care physician. Thus far on the record we have had to testimony on addiction withdrawal from Dr. Jacobs, Dr. Farone, Dr. Groff, Dr. Goldman and Dr. Tinsley. This will be number six.

MR. LYDON: It's also kind of cumulative.

MR. ACOSTA: It's not, Your Honor. Every time they ask questions about what did doctor --

THE COURT: Did he actually counsel the plaintiff?

MR. ACOSTA: Yes, and he was within the first 11 months.

THE COURT: All right. I will permit it.

MR. ACOSTA: Thank you. It's only two pages. The sound is not very good, but it's better

than Dr. Tinsley's.

THE COURT: Do we need the lights adjusted?

MR. ACOSTA: We will when I find it on the screen.

(Whereupon, the videotaped deposition testimony of Robert B. Burchett, M.D. was played to the jury, as follows:)

BY MR. ACOSTA:

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Q. Dr. Burchett, Howard Acosta.
MR. ACOSTA: The sound is not that bad. We're not getting the sound through that speaker. We are getting it through the computer.
BY MR. ACOSTA:
Q. Dr. Burchett, I'm Howard Acosta and I represent John Eastman. Have we ever met before today?
A. No.
Q. And before I ask you questions about your care and treatment of Mr. Eastman, would you tell us where you went to medical school and when you graduated?
A. I went to the University of Dominica in the Caribbean, graduated in 1981. Did a three-year residency at Washington University in St. Louis in internal medicine, finished in 1984. And I've been practicing since then in primary care, internal medicine.

THE COURT: I was going to say, this is supposed to be the good audio.
MR. ACOSTA: This is the worse part of it and it gets better. It has a couple bad parts. We can read the answers to the few places where it's difficult to hear him, which we will be happy to do if they would like. Do you want to read the answer to that question?
MR. PARRISH: I didn't hear the question, Your Honor.
MR. ACOSTA: "And before I ask you questions about your care and treatment of Mr. Eastman, would you tell us where you went to medical school and when you graduated?
Answer: "I went to the University of Dominica in the Caribbean, graduated in 1981. Did a three-year residency at Washington University in St. Louis in internal medicine, finished in 1984. And I have been practicing since then in primary care internal medicine."
"And can you tell me a little bit about your residency and then any post residency board training or board certification or things like that that you might have been involved in after 1981."
"Just the standard general internal medicine

residency for three years and no training since then. I am not board certified in internal medicine."
MR. ACOSTA: Let me try to continue this.
(Whereupon, the playing of the videotaped deposition continues, as follows:)
BY MR. ACOSTA:
Q. And can you tell me a little bit about your residency and then any post residency training or board certification or things like that that you have been involved in after 1981?
A. Just the standard general internal medicine residency for three years and no training since then. I'm not board certified in internal medicine.
Q. Is there any particular reason why you're not board certified?
A. I haven't passed the exam.

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Q. Do you work with another physician currently?
A. Yes.
Q. And have you been since 1981?
A. Well, I graduated in '81. I was in residency until '84.
Q. Okay. Since '84?
A. Yeah. I think I came -- I worked part time for him originally in '85, I think it was. And I

started and probably have been full time since about '86.
Q. And have you been in Tampa since then?
A. Yes.
Q. And I take it you're licensed to practice medicine in the state of Florida?
A. Yes.
Q. And you're licensed to prescribe drugs of all sorts?
A. Yeah.
Q. And as an internist, what is the -- most of the patients you see I take it are adults?
A. They are all adults.
Q. And --
A. Over the age of 12.
Q. And if they need specialized care, then you would refer them out to another doctor?
A. Yes.
Q. Generally is your practice similar to a family practitioner?
A. Yes, except we don't really see children or heavy gynecology stuff. Otherwise, it's primary, pretty primary care. Similar to a family practice.
Q. So in any event, back in May of 1996, Mr. Eastman came to see you for the first time?

A. Yes.
Q. And he filled out a questionnaire?
A. Yes.
Q. I would like to ask you some questions about what was reported to you about Mr. Eastman at the time.
Do you take the information in the questionnaire and use it as part of a history of the patient?
A. Yes.
Q. And what is the purpose of taking a history?
A. To try to determine the problem at hand.
Q. Well, what was Mr. Eastman's chief complaint when he came to see you?
A. Yeah. I'll say shortness of breath.
Q. And on the questionnaire, I believe that indicates a series of questions regarding past history. And it appears that there are a number of boxes after --
A. Could you refer to the page?
Q. -- illnesses. That would be page 0007?
A. Yes.
Q. Now, under past history at the very top.
THE COURT: Mr. Acosta, our court reporter is unable to get some of this audio.
MR. ACOSTA: Well, I guess we could read it, then, if that would be preferable. We have the

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deposition, which we can give her a copy so she could transcribe it from the lines that were designated for him.

THE COURT: Okay. Would the jury prefer to be read or watched.

THE JURY: Read.

THE COURT: I guess they are having the same trouble we are. It's hard to tell.

MR. ACOSTA: The sound goes and comes. Sometimes it is better than it is at other times and it's been about as bad as it gets. It doesn't get any worse than it's been, but it does have better spots in it. So that's all I can say on the subject.

THE COURT: Well, it's just amazing in today's technological world that we can't have a better product than this. But I understand that limitations sometimes exist.

MR. ACOSTA: I don't know how to explain it, but it's what we have.

THE COURT: It's your evidence. However you wish to proceed.

MR. ACOSTA: I think we will just try to go ahead with it like this, unless it gets to the point where nobody can hear it.

(Whereupon, the playing of the videotaped deposition continues, as follows:)

BY MR. ACOSTA:

Q. At the very top did Mr. Eastman check any of the "no" boxes?

A. No.

Q. Did he check all of the "yes" boxes?

A. No.

Q. Does that mean he left some -- or many of the boxes blank?

A. Yes.

Q. And how -- what is it, four "yes" boxes that he checked out of 20 or so?

A. Yes.

Q. And then beneath that he had past operations, which included testicular cancer in 1962 and then a penile implant and then patella operation in 1984?

A. Yeah.

Q. Then on the next page there's a question that says, "Have you ever smoked tobacco?" How did he respond to that?

A. Yes. He put yes.

Q. And then the next question is, "Are you a regular smoker now?" And how did he respond to that?

A. He put no.

Q. And why is it that you ask patients if they've ever smoked tobacco?

A. Because we think that smoking tobacco causes chronic lung disease. Or may -- change -- may cause chronic lung disease.

Q. And do you see patients regularly that come to you with chronic lung diseases?

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A. Yes.
Q. Do you see patients that come to you with a disease called COPD?
A. Yes.
Q. And is COPD an acronym or initials that mean chronic bronchitis, emphysema, or asthma?
A. It's made up of the combination of those, usually a combination of all three of those to one degree or another, yes.
Q. Okay. Asthma, though, would be -- is it a separate disease from emphysema?
A. Yes.
Q. And is chronic bronchitis a separate disease from either asthma or emphysema?
A. Yes.
Q. In Mr. Eastman's case, during the time that you saw him from 1996 until 1998, did you ever determine

what kind of COPD he had?
A. You mean whether predominantly chronic bronchitis, predominantly emphysema?
Q. Yes.
A. I did not, no.
Q. Now, in the -- do you see patients that have chronic bronchitis and/or emphysema on a regular basis?
A. Yes.
Q. Is cigarette smoking considered a significant contributing cause of COPD?
A. Yes.
Q. And I believe that you took, in addition to this smoking history of Mr. Eastman, somewhere in your records was there an indication that he had approximately a 100-pack-year smoking history?
A. I believe that's Dr. Modh's determination, yeah.
Q. And that was one of the letters you signed off on?
A. Yes.
Q. And a 100-pack-year smoking history would be equal to two packs a day for 50 years?
A. Yes.
Q. Is that a significant amount of cigarette smoking?

A. Yes.
Q. Based on that smoking history and his diagnosis of COPD, is it likely that Mr. Eastman's COPD was caused by his cigarette smoking?
A. Yes.
Q. Now, we talked a little bit about his alcohol consumption and past drug use. And he indicated in this questionnaire at page 008 that -- the choices under "Alcohol" involving beer was one bottle per day, two bottles and then three or more; is that correct?
A. Yes.
Q. And I believe you said that he checked the two bottles a day box?
A. Yes.
Q. And then when you asked him how much he was drinking a day, I believe you said two to three; is that correct?

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A. Yes.
Q. Is two -- he didn't tell you he was drinking three or more, did he?
A. No, he didn't.
Q. He said two to three. So would two to three be what his statement to you was?
A. Yes. But it's not a choice here.
Q. Then under "Review of Systems" on page 009 of

your records, which would be, again, the questionnaire that he filled out when he first came to your office in May of '96, it says under "General" -- can you tell us what problems he had under the "General" review?
A. Well, he checked "Yes" for "Do you usually feel tired or worn out?" That's the only one he checked yes for.
Q. The one beneath that has a line through it.
A. Well, he crossed -- well --
Q. Through both of them?
A. For the question "Do you feel sad a lot of the time?" he -- I don't know what that means. He put a line through it. I don't know what to make of it.
Q. Did you question him as to whether he felt sad a lot of the time?
A. I started him on antidepressant, and I note that he had gone through a divorce recently. But I guess I don't specifically have a comment about that.
Q. The question above it says, "Do you usually feel tired or worn out?" Do you know how far back in time he had been feeling tired, fatigued or warn out?
A. I don't know.
Q. This was a record of Dr. Tinsley?
A. Yes. But when he came -- you're asking was he on it before only, right?

Q. Yes. Was he on Zoloft before coming to see you?
A. It looks like yes.
Q. And that is an antidepressant?
A. Yes.
Q. In looking at Dr. Tinsley's record under "Assessment and Plan," the No. 1 assessment was COPD?
A. Yes.
Q. Then going back to 009, your intake questionnaire, there's a question that says "Do you have pain, tightness or pressure in the front or back of your chest?" And he marked -- what did he mark for that?
A. He marked yes.
Q. And then the next question is, "If yes, is it when walking fast, working hard or when excited?" And how did he mark that?
A. He marked yes.
Q. Are yes answers to those two questions consistent with COPD?
A. Yes.
Q. Now, if you look up above under his occupational history, was he unemployed at the time or not?
A. He has this time not a line, but he's checked both yes and no.

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Q. Okay. And then you were asked some questions about his hobbies and it said, "Have you discontinued activities that were satisfying?" And he -- what did he mark?
A. He put no.
Q. When was he hospitalized with the pneumonia?
A. I mean, I could probably answer that now. I think I saw it -- here's a -- I don't know if you have this or not. There's a discharge summary. It was June 10 to June 20, 1995. I have a discharge summary from Dr. Tinsley.
Q. Well, looking back now --
A. Yes.
Q. -- was there any hospitalization for pneumonia after June of '95 through May of '96 when you saw him?
A. Not that I'm aware of.
Q. So then he would have been not smoking for how long when you first saw him?
A. Eleven months.
Q. Let me ask you, have you counseled smokers to stop smoking in the past?
A. Ad nauseam.
Q. And are you always successful in getting them to stop?
A. No.

Q. And why not?
A. I believe it's a very strong addiction.
Q. And with respect to that addiction, when a -- are there symptoms associate with stopping when someone is addicted to smoking?
A. Yes.
Q. And they call it withdrawal symptoms?
A. Yes, withdrawal symptoms.
Q. Well, let me ask you this: When are the withdrawal symptoms experienced by a smoker who has stopped smoking?
A. Quickly, as you -- within hours to days after stopping.
Q. Is it normal for someone to experience acute withdrawal symptoms 11 months later?
A. With nothing in between you mean?
Q. Yes.
A. No. I mean, that's unusual, yeah. It's unusual.
Q. It would be unusual. Would it have been unusual for Mr. Eastman to still have withdrawal symptoms 11 months later?
A. People still crave, I mean, crave smoking. To answer your question, I guess it would be unusual, yes.
Q. Aside from the craving, would it be unusual?

A. I'll say yes.
Q. Would there have been any need for Mr. Eastman to get nicotine replacement therapy or any other aid at the time you saw him 11 month after he had quit smoking?
A. No.
Q. Have you had patients in the past that have stopped smoking during a hospitalization for a serious or severe illness?

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A. Yeah. They have to. I mean, you don't get a choice.
Q. Why is that?
A. You can't smoke in the hospital. I mean, they would have to -- especially at an intensive care unit or something. I suppose they could get around it if they were -- you know, they could go outside or something to smoke.
Q. And did Mr. Eastman -- well, let me ask you. What is the significance of your statement "he stopped seven month ago when he was hospitalized with severe pneumonia" in terms of his stopping, if anything?
A. What significance does it have? Time to date his -- when it was, and it's a somewhat believable situation to stop smoking.
Q. And what makes it somewhat believable in his case?

A. Well, because you can't smoke in the hospital, I mean, basically. People become -- patients become more teachable about smoking when they have an illness related to it or possibly related to it. They are more -- they are at a teachable moment. They can -- they are more likely to respond to stopping when something -- when they can see a relationship.
Q. Is a person on oxygen permitted to smoke?
A. No. No.
Q. Why not?
A. Because the oxygen is combustible. It could cause an explosion.
Q. Then you indicate when you first saw him that he had shortness of breath and dyspnea on exertion. What did you mean by that?
A. Dyspnea on exertion is shortness of breath when he exerts himself. When he tries to do things, he exacerbates his breathing.
Q. Is there a difference between dyspnea and shortness of breath?
A. No. But I think I'm trying to say that shortness of breath would be, you know just short of breath all the time as opposed to dyspnea on exertion. Maybe that's the distinction I'm trying to make, if any.
Q. Yeah, because it says, "Since then he had

shortness of breath and dyspnea on exertion." So what I'm trying to figure out is what you meant by including both phrases in that sentence?
A. I don't know, but I could take it to mean that he's short of breath at rest.
Q. And then what do you say next?
A. He cannot walk up a flight of stairs without getting short of breath or walk long distance without resting.
Q. Was there any other history that he gave you that is significant in your mind to his shortness of breath or dyspnea?
A. No.
Q. Then you formed a diagnosis on that first visit in May of 1996?
A. Yes.
Q. And what was your diagnosis?

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A. Chronic obstructive pulmonary disease.
Q. And then one of the items under your plan is for him to take inhalers and Zoloft; is that correct?
A. Yes.
Q. Another is for him to lose weight. It appears that he's six feet at 215 pounds.
A. Yes.
Q. How much weight did you think that it would be

good for him to lose?
A. Maybe 20 pounds; 20, 30 pounds.
Q. Now, someone with COPD, do they -- does COPD cause them to be real sedentary due to their shortness of breath?
A. Yes.
Q. Is gaining weight a symptom of smoking abstinence or smoking cessation?
A. It can be, yes.
Q. How significant, if at all, was Mr. Eastman's weight at 215 at six feet tall?
A. It's another factor. I get less worried about obesity in people with chronic lung disease because they tend to lose weight just from their disease alone over time. In fact, we tend to augment their diet further on.
Q. Did you anticipate that he would eventually continue to lose weight?
A. Yes.
Q. Then if you would, turn to 0021. That would be the lab results of about ten weeks later after your first visit; is that right?
A. Yes.
Q. And I see one of the criteria with a circle around it, and it says "Good" with an exclamation point?

A. Yes.
Q. And what was meant by that?
A. That was just that he had good HDL, the so-called protective cholesterol. Good in the face of his otherwise -- I think his total cholesterol was high.
Q. There's an LDL right under it.
A. LDL is bad. At that time -- when is this, '96? My criteria for good, I might not have circled good nowadays. That's changed. But back then, yes, I thought that the HDL was protective on -- I don't see -- oh, here is his total cholesterol, 271, was high.
Q. Now, did he have any what you would consider to be abnormal findings on his laboratory work in August of '96?
A. Well, he had high lipids, high LDL, high total cholesterol, slightly high triglycerides. But he also had this somewhat protective HDL. I mean, it was --
Q. So was it anything that you were significantly concerned about?
A. He should be on a low fat diet like everybody else. I wasn't treating it with medication, if that's what you --
Q. Okay. When people are chronic abusers of alcohol, do you see laboratory indications of that?
A. You can.

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Q. And what would you usually see if someone was chronically abusing alcohol?
A. Well, liver function abnormalities, liver function test abnormalities, which he does not have.
Q. Okay.
A. And you can see -- in my experience and I think others' experience, the MCV, one of the -- the size of the red blood cells get bigger in kind of closet alcoholics and people who -- and not just closet alcoholics, just alcoholics in general because they are not getting the -- I guess the theory is that they're not getting the nutrients to build the red blood cells. He does not have that. There's other things like that, I mean. But they are not hard and fast, and you don't have to have them. But he doesn't have them.
Q. Okay. Well, so he -- does he have any indications on his lab work that would suggest to you that he was a heavy drinker?
A. No. I would say no.
Q. Okay.
A. That doesn't mean he's not. But he doesn't have -- to answer your question, no, he does not.
Q. Well, based on the things that he told you and based on your examination and based on his visits and based on his lab work, did you have any indication that

he had any problem with alcohol?
A. I mean, he keeps stating that he's drinking. I don't know if that's a problem. He says that he drinks, you know, all through here. Most of the way through he said he drinks two, three, four beers.
Q. Okay.
A. Is that a problem? I don't know.
Q. That's what I'm trying to find out. Did you diagnose any problem yourself with alcohol?
A. I was more worried about his breathing, but I don't consider that terrible, no. I would rather he didn't do it, but --
Q. How about a couple drinks; is that okay?
A. I would say a couple drinks is okay.
Q. And you mentioned that all through here -- well, I'm going to go through those because oat one point you were asked a question.
Why don't we go to 0040. That's March of '97. Under "Social history" it indicates social alcohol.
A. Yes.
Q. If -- and was this a report that was taken by another physician in your office?
A. A medical student.
Q. If there had been a problem, is that medical student trained to put something other than social

there?
A. Yes.
Q. Is social alcohol considered generally to be a problem?
A. No.
Q. And then the next visit was on 0041. And that, again, is a report made by a resident that's working with you?

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A. Yes.
Q. In fact, the one that I just mentioned, 0040 and 0041, you signed off on those, right?
A. Right. Well, but as we determined earlier, the one from 4/24/97 was actually -- that corresponds to Dr. Rosenthal's dictation that's 0044.
Q. Okay.
A. I think I signed off just because there was no -- nobody signed off later on when we go through the records. Probably when -- probably when you requested the record or you guys requested the records, I probably saw that no one had signed off on it and signed it.
Q. So you signed it?
A. So I signed it.
Q. All right. Well, for "Social History" there it says --
A. But I did not see him that day, I guess.

Dr. Rosenthal saw him.
Q. Okay. Well, up there it says, on that record of April of '97, it says "occasional alcohol;" is that right?
A. Right. Yes.
Q. Is occasional alcohol the same thing as social or is it less or what does that mean?
A. I would take it to mean less. It's not that specific. It's not suggestive of a drinking problem, if that's what you're --
Q. Okay. And then I notice that you dictated this report in your office notes on 0044. Does that -- that pertains to that particular visit?
A. Yes. That correspondence to that visit, yes.
Q. Does it indicate there's any alcohol -- even any alcohol use in the narrative --
A. I think it just --
Q. -- narrative report?
A. -- isn't mentioned one way or the other.
Q. Okay. Then we -- you were asked about 0073, which is a report about -- I guess that's about --
A. This is from Dr. --
Q. -- a year later.
A. March of '98.
Q. Is that about a year after the -- it's 11

months after the '97 visit that we just discussed?
A. Yes, it is.
Q. And that's 0073?
A. That was April '97 versus this is March '98.
Q. And this is a letter to you from a Dr. Modh who was a pulmonary or a lung doctor?
A. Yes.
Q. Did Mr. Eastman, after you saw him in May of '96 up through April of '97, ever report more than two or three or three or four beers a day?
A. No.
Q. And then in March of '98, approximately 11 months later, it indicates that he is drinking less than before; is that correct?
A. That's correct.
Q. So in any event, at any time did you diagnose any disease that you felt was caused by any alcohol

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consumption on the part of Mr. Eastman?
A. No.
Q. Did you at any time feel that he had any significant problem from drinking two or three drinks a day?
A. No.
Q. And in terms of it might have helped him to feel better if he didn't drink at all, in what sense

might it have helped him to feel better if he didn't drink at all?
A. Again, I'm not encouraging him to drink. I don't know how to answer this.
Q. Well, I believe there's --
A. I would rather he didn't drink, period. I don't have a problem with small amounts of alcohol.
Q. In what sense, if at all, would not drinking at all would have helped him?
A. I guess I don't share Dr. Modh's insistence on decreasing -- on -- I mean, I would like him to decrease the alcohol. Nutritionally, it's not the best thing. I mean, kind of common sense things. I don't know how to directly answer it.
Q. Did it have anything --
A. What is your question? What was your original question?
Q. Did the alcohol have anything to do with his chronic obstructive pulmonary disease?
A. I'll say directly, no.
Q. Can a person lose a lot of capacity from a chronic disease and if they have a sedentary lifestyle not know it until some dramatic event?
A. Simple answer: Yes.
Q. And why is that?

A. Well, because we -- there's a reserve ability of the lungs to work that you may never be called upon to use until you exert yourself. And a sedentary person may never discover it until they do something. And as you age, you're losing alveolus and things. I mean, it's a cumulative, chronic process.
Q. The alveolus tha6t you're talking about, those are the air sacs?
A. Little air sacs, yeah.
Q. And based upon your knowledge and training, are those lost in someone that has emphysema?
A. Yes.
Q. Do you remember seeing in your records a reference to a diagnosis of emphysema with respect to Mr. Eastman?
A. You mean specific emphysema? These terms are thrown around, you know, broadly.
Q. Look at --
A. Technically chronic obstructive lung disease is not just emphysema.
Q. I understand. If --
A. Are you going to show me somewhere?
Q. Yeah. Dr. Modh's letter to you of October '96, which is 0038.
A. Yes.

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Q. All right. In the first paragraph --
A. "Probably has emphysema."
Q. Do you normally determine things on the basis of probability in terms of making your diagnosis?
A. Yes.
Q. Let me read it to you. It says, "He has undergone PFT, which shows that the patient has only about 37 percent FEV1 with sever obstructive lung disease."
Is emphysema a sever obstructive lung disease?
A. It is.
Q. Can you explain what 37 percent of FEV1 is with respect to Mr. Eastman?
A. That he's only able to do -- I mean, you could look at it the way that you just interpreted it, only 37 percent of what a normal person could blow out in one second.
Q. And then it says, "There is some change after broncodilators and also has a significant reduction in diffusion capacity." Now, what is diffusion capacity?
A. Diffusion capacity, to my knowledge, is the ability of the alveolus to exchange gases from the bloodstream into the -- into the lung.
It's destroyed in emphysema as opposed to chronic bronchitis. It's technical jargon and a

technical test to try to determine the different kinds of lung diseases that make up chronic obstructive lung disease.
Q. With a 37 percent FEV1 and a significant reduction in diffusion capacity, would you agree with Dr. Modh where he is "suggesting that patient probably has emphysema associated with this"?
A. I would agree. He's a pulmonologist.
Q. And if you look at 0036, which is -- would you tell us what that is?
A. This is a report by a radiologist of a chest x-ray from October 1996.
Q. And does that correspond with Dr. Modh's visit in October of '96 in some way?
A. Yes.
Q. And what did the radiologist look at?
A. He interpreted it as signs of emphysema is what he -- is his final conclusion.
Q. And your signature on this?
A. Yes.
Q. It says "Date Reviewed, 10/15/96"?
A. Yes.
Q. And what kind of a disease is emphysema in terms of its prognosis or future effect?
A. It's a continually destructive disease to the

alveolus, to the breathing air sacs, and accumulation of stale air in the lungs that can't be exchanged, can't get re-exchanged because the alveoli are no longer working as they used to.
Q. Does it -- does it cause impairment?
A. It causes shortness of breath. Gradual, progressive.
Q. Until what?

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A. Until death. I mean, slow. Slowly. It doesn't -- it's not quick.
Q. Is emphysema a fatal disease?
A. It's a fatal disease.
Q. Oh, do inhalers cure emphysema?
A. There's no cure for emphysema, so no.
Q. Well, tell me, was Mr. Eastman on any lung medication when he first came to see you?
A. According to my notes, he was not.
Q. Did he come to see you to get refills or to get new lung medication?
A. Yes.
Q. And so, did you prescribe for him some inhalers of medications to help him breathe?
A. Yes.
Q. And so did you prescribe for him some inhalers of medications to help him breath?

A. Yes.
Q. Well, let me ask you: Did you use them in the manner in which you hoped he would use them?
A. No.
Q. And what happened in that respect?
A. What happened? He became worse.
Q. Are they easy to use?
A. No.
Q. Why aren't they easy to use?
A. It takes eye-hand coordination that people typically don't have. There's several reasons.
Q. Initially, he was prescribed the inhalers to use them so many time a day; is that right?
A. Yes.
Q. Well, did you ever tell him he could use them as needed?
A. Probably.
Q. Why did it get to the point where you told him that he could simply use the inhalers when he wanted to?
A. I mean, that's not what Dr. Modh has done, but there's places where I guess I did. And -- because it's never been proven that inhalers -- that they even help, that they may necessarily help for people with chronic lung disease as opposed to asthma. They definitely help with asthma. They may or may not do some good for

people with chronic lung disease or emphysema.
Q. And those that have chronic lung disease like emphysema, do they have permanent destruction of the tissues?
A. Right.
Q. Does the inhaler --
A. It has no place --
Q. -- restore it in any way?
A. No. But it can -- I mean, this is a very difficult question that you probably don't want to go into right now, but COPD is a combination of -- there can be an asthmatic component. You know, people have various components, asthma, chronic obstructive lung disease and emphysema. So you try to treat what you can.
Some respond more to bronchodilators than others do. So that's why I may not -- I may not have

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been pushing it like it sounds like Dr. Modh did push it more than me.

Q. So what I'm trying to figure out is where do they fit then if they are not a cure and they are not palliative, what would -- what do they do for somebody like him?

A. Okay. This is me speaking. Chronic obstructive lung disease, other than getting -- I think

I said it earlier, other than getting people to stop smoking, there's not a lot of things proven that can really help them. And so we do what we can do of the available things. And some people have a better response to bronchodilators than others do. So we just kind of throw -- I mean, at least -- I shouldn't say we -- I try to treat whatever I can treat or possible treat, especially in a disease that's fatal that has no cure.

MR. ACOSTA: That would be the final portion of this deposition.

THE COURT: All right. I believe I have received a request from one of the jurors to start at 8:30 tomorrow. Are there some of you who would like to start at 8:30 tomorrow? Don't be shy. We can certainly start at 8:30 if you would like. If that doesn't work for somebody. Is there anybody who cannot start at 8:30 tomorrow?

THE JURY: Fine (collectively).

THE COURT: This okay with everybody? Actually, it might be better to start at 8:30 and get more in the morning; although, we are on schedule. So I know that it sometimes seems tedious, but we are coming -- I think the plaintiff was planning on concluding plaintiff's case in the

next few days. All right. Well, we will see you all at 8:30 tomorrow morning. Thank you very much.

(Whereupon, the jury left the courtroom.)

THE COURT: Well, I volunteered you for 8:30 tomorrow. Are you going to be ready to go?

MR. ACOSTA: I think we can handle it.

THE COURT: Here is a cryptic note, 8:30. Perhaps I should have assumed they wanted to go until 8:30 tonight. You are a student of body language.

Okay. Is there anything else we need to do to get ready for them at 8:30 tomorrow?

MR. ACOSTA: I don't think so.

THE COURT: Is the defense going to be reading or playing that?

MR. LYDON: We will be reading, Your Honor.

MR. ACOSTA: I probably need to finish couple more lay depositions, publish some documents and publish Dr. Heiman's deposition and then it's possible I may get to Mr. Eastman in the afternoon sometime. Probably will start Wednesday at 8:30 with Mr. Eastman.

MR. PARRISH: We are still waiting for a copy of the Heiman deposition. I would like to see that deposition before it's put on.

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MR. ACOSTA: It's crashed on the computer last night, so we have to reload it tonight and we can redeliver that document.

THE COURT: Okay. Very good. Let's be ready to go at 8:30 tomorrow. Be here before that.

THEREUPON, the trial concluded sine die.

REPORTER'S TRIAL CERTIFICATE

STATE OF FLORIDA)
COUNTY OF PINELLAS)

I, TONYA HORNSBY-MAGEE, Registered Professional Reporter, certify that I was authorized to and did stenographically report the trial of the foregoing proceedings; and that the transcript is a true and complete record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, attorney, or counsel of any of the parties, nor relative or employee of such attorney or counsel, nor financially interested in the outcome of the foregoing action.

Dated this 25th day of March, 2003, at Clearwater, Pinellas County, Florida.

_____
TONYA HORNSBY-MAGEE, RPR

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